Older Women’s Experiences of Intimate Partner Violence: A Phenomenological Study

Lourdes Irene

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Older Women’s Experiences of Intimate Partner Violence:
A Phenomenological Study

A Dissertation Presented
by
LOURDES IRENE

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ABSTRACT

OLDER WOMEN’S EXPERIENCES OF INTIMATE PARTNER VIOLENCE: A PHENOMENOLOGICAL STUDY

SEPTEMBER 2020

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Directed by: Professor Karen Kalmakis

Intimate partner violence (IPV) is a global public health problem, linked to long-term health, social, and economic consequences. Despite the growing number of women over age 60 in Puerto Rico, knowledge is lacking about culturally specific IPV in women of this age group. This lack of knowledge is problematic because women experiencing abuse often do not report it, health professionals are not educated to identify cases of abuse in older women, and researchers often includes IPV with other types of abuse, such as negligence by families. Therefore, the purpose of this study was to explore and describe the experiences and perceptions related to the phenomenon of IPV in Puerto Rican women over 60 years of age. An interpretative phenomenological approach was used to understand the experiences of older Puerto Rican women exposed to IPV. Data was collected using in-depth interviews and then carefully read and analyzed to identify codes and themes according to Colaizzi’s strategy (1978). A total of six women participated in this research study. Five emerging themes were used in the analysis and interpretation. These were adverse childhood experiences, IPV influences, IPV implications, support structure for coping with IPV, and coping strategies. The findings
revealed that participants begun to experience adverse events in childhood. These events influenced the IPV experience in the relationship. Exposure to IPV initiated at the beginning of the relationship and lasted until after the age of 60. The patriarchal culture factors also influenced the experience of IPV. These experiences are related to harmful effects on mental and physiological health. The health management and early identification of IPV, along with referrals to centers dealing with trauma or violence, help the victim receive the appropriate interventions to break the cycle of violence.
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CHAPTER 1

INTIMATE PARTNER VIOLENCE

Introduction

Background and Statement of the Problem

IPV experience may be associated with several risk factors (Niolon, Kearns, Dills, Rambo, Irving, Armstead, et al., 2017). Gerino, Caldarera, Curti, Brustia, and Rollé (2018) in their systematic review of articles report presented numerous studies related to risk factors for IPV. Table 1 summarizes those findings: the individual, relationship, community, and societal factors that influence the occurrence of IPV (Gerino, et al., 2018; Niolon, et al., 2017).

Individual factors include demographics (low income, and low academic achievement), personal history (prior history of being physically abusive), and personality factors (depression and personality disorders) (Niolon, et al., 2017). Low income is consistently linked to a man's likelihood of physically assaulting an intimate partner (Guedes, Alvarado, Phillips, Curcio, Zunzunegui & Guerra, 2015). Abuse rates were higher among women whose husbands had experiences of being prior history of trauma. (Policastro & Finn, 2017). Emotional instability and mood changes can be risk factors for IPV (Nam, & Lincoln, 2017).

Several researchers have conducted studies where they have identified that mental disorders are related to IPV (Gerino, et al., 2018). Male perpetrators of IPV are more likely to have an antisocial personality and to exhibit behaviors of verbal and physical aggression. This personality type is associated with physical violence to the couple. On the other hand, borderline traits including anger, difficulty controlling anger, and fear of
separation are all associated with different types of IPV (Sijtsema, Baan, & Bogaerts, 2014).

Relationship factors are related to an interpersonal level. Two of the markers that are associated with IPV are conflict and discord in the relationship (Niolon, et al., 2017). Verbal marital conflicts and economic problems are significantly related to physical assault of the wife (Miszkurka, Steensma & Phillips, 2016; Souto, Guruge, Merighi, & de Jesus, 2016). Another trait associated with relationship factors is male dominance, which is associated with physical assault, victimization, and perpetration (Lasley & Durtschi, 2015).

Community factors are related to poverty and norms that shape a community. Golden, Pereira, and Durrance (2013) found that economic difficulties, low education levels, and limited control over household finances significantly increased the risk of becoming victims of emotional abuse and IPV. Poverty, or a lack of economic resources, was often accompanied by verbal violence exerted by the intimate partner (Mayorga, 2012; Han, Jeong, & Kim, 2017).

Societal factors are also related to IPV. These reveal structural inequalities between men and women, rigid gender roles, and notions of manhood linked to dominance (Niolon, et al., 2017). Women with more traditional gender beliefs experience higher rates of physical abuse and IPV (Santos, Nunes, Kislaya, Gil, & Ribeiro, 2017; Crockett, Brandl, & Dabby, 2015). For example, the Puerto Rican culture has a strong gender differentiation, which is reflected in all aspects of sexual expression and male-female interaction (Montesinos, Preciado, Velázquez, Rosario, & Ríos, 2002). Racial factors are also related to IPV (Golden et al., 2013). The rate of IPV is higher among
Hispanic and immigrant women (Golden et al., 2013). It is important to promote policies and programs that foster gender equity in partnerships, since this may potentially reduce the multiple forms of IPV (Golden et al., 2013).

Table 1: Factors Contributing to IPV

<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>Risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guedes, et al.</td>
<td>2015</td>
<td>Low income</td>
</tr>
<tr>
<td>Han, et al.</td>
<td>2017</td>
<td>Low academic achievement</td>
</tr>
<tr>
<td>Nam &amp; Lincoln</td>
<td>2017</td>
<td>Depression</td>
</tr>
<tr>
<td>Qin &amp; Yan</td>
<td>2018</td>
<td>Mental disorders</td>
</tr>
<tr>
<td>Sijtsema, et al.</td>
<td>2014</td>
<td>Personality disorders</td>
</tr>
<tr>
<td>Policastro &amp; Finn</td>
<td>2017</td>
<td>Prior history of Trauma</td>
</tr>
<tr>
<td>Miszkurka, et al.</td>
<td>2016</td>
<td>Marital conflicts/fights</td>
</tr>
<tr>
<td>Souto, et al.</td>
<td>2016</td>
<td>Marital instability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unhealthy family relationships and interactions</td>
</tr>
<tr>
<td>Lasley &amp; Durtschi</td>
<td>2015</td>
<td>Male dominance in the relationship</td>
</tr>
<tr>
<td>Golden, et al.</td>
<td>2013</td>
<td>Poverty and associated factors, relationship, and norms that shape a community’s social interactions and weak community sanctions against IPV</td>
</tr>
<tr>
<td>Mayorga</td>
<td>2012</td>
<td></td>
</tr>
<tr>
<td>Han, et al.</td>
<td>2017</td>
<td></td>
</tr>
<tr>
<td>Santos, et al.</td>
<td>2017</td>
<td>Traditional gender norms (e.g., women stay at home and are submissive; men support the family and make the decisions of household finances)</td>
</tr>
<tr>
<td>Crockett, et al.</td>
<td>2015</td>
<td></td>
</tr>
<tr>
<td>Montesinos, et al.</td>
<td>2002</td>
<td></td>
</tr>
</tbody>
</table>
In addition to the risk factors associated with IPV, there are several health consequences related to IPV (Niolon, et al., 2017), these include both physiological and psychological conditions (Table 2). Indeed, Winter, Obara, and McMahon, 2020 found that continuous exposure to physical abuse by an intimate partner is strongly associated with poor health status. Older women who are being psychologically abused are more likely to report a higher number of health conditions such as depression, anxiety, digestive problems, and chronic pain (Baloushah, Mohammadi, Taghizadeh, Taha & Franam, 2019; Stöckl & Penhale, 2015). Women with poor health become further dependent on the abusive partners, leading them to remain in the relationship, and subsequently continue their exposure to the emotional and physical violence (Sanders, 2015).

Table 2: Health Consequences Associated with Intimate Partner Violence

<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>Health Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campbell, Anderson, McFadgion, Gill, Zink, Patch, Callwood, &amp; Campbell, Monahan, Purushotham, &amp; Biegon</td>
<td>2018</td>
<td><strong>Nervous system:</strong> Nervous disease Headaches Migraines Seizures Memory problems</td>
</tr>
<tr>
<td>Suglia, Sapra, &amp; Koenen El-Serag, &amp; Thurston</td>
<td>2015</td>
<td><strong>Cardiovascular system:</strong> Cardiovascular disease High blood pressure Stroke</td>
</tr>
<tr>
<td>Pallotta, Piacentino, Ciccantelli, Rivera, Golini, Spagnoli, Vincoli, Farchi, &amp; Corazziari</td>
<td>2014</td>
<td><strong>Gastrointestinal system:</strong> Inflammatory bowel syndrome Diarrhea Constipation Gastric Reflux Indigestion</td>
</tr>
<tr>
<td>Authors</td>
<td>Year</td>
<td>Health Conditions</td>
</tr>
<tr>
<td>---------</td>
<td>------</td>
<td>-------------------</td>
</tr>
</tbody>
</table>
| Fanslow, Wise, & Marriott | 2019 | **Genitourinary system:**  
Bladder infection  
Genitourinary problems  
Pelvic pain  
Dyspareunia |
| Alhalal, Ford-Gilboe, Wong, & AlBuhairan | 2018 | **Immune and endocrine system:**  
Chronic pain  
Metabolic syndrome  
Diabetes |
| Chandan, Thomas, Raza, Bradbury-Jones, Taylor, Bandyopadhyay, & Nirantharakumar | 2020 | **Musculoskeletal system:**  
Activity limitation  
Joint disease  
Arthritis  
Physical disabilities |
| Breiding Basile, Smith, Black, & Mahendra | 2008 | **Reproductive system:**  
Menstrual symptoms  
Vaginal dryness  
Dyspareunia  
Sexual dysfunction  
Chronic pain |
| Lutgendorf, M. A., Snipes, M. A., & O’Boyle | 2017 | **Psychological conditions:**  
Anxiety  
Depression  
Post-traumatic stress disorder  
Sleep disturbances  
Psychological distress |
| Gibson, Huang, Mccaw, Subak, Thom, & Van Den Eeden | 2019 | **Somatic conditions:**  
Chronic fatigue  
Fibromyalgia  
Temporomandibular disorder  
Chronic pain |
| Beck et al. | 2014 | |
| Baloushah, et al. | 2019 | |
| Stöckl & Penhale | 2015 | |
| Chandan, et al. | 2019 | |
| Fisher, Zink, & Regan | 2011 | |

Having identified the risk factors and consequences of IPV, it is important to describe the types of IPV that can occur between couples. There are four main types of
partner violence. The first is physical violence, which relates to the intentional use of physical force (Breiding, et al., 2015). The second is sexual violence, which includes five categories: (a) rape of the victim with physical force, (b) victim-forced penetration of someone else, (c) unwanted penetration, (d) unwanted sexual contact, and (e) other noncontact unwanted sexual experiences (Breiding et al., 2015). The third type of partner violence is stalking, which entails an unwanted pattern of behaviors by the perpetrator that cause fear or concern for safety for the victim or someone close to the victim (Breiding et al., 2015).

The fourth type of IPV is psychological aggression, which is the use of verbal and nonverbal communication to harm another person mentally or emotionally. This includes psychological aggression (e.g., humiliating), coercive control (e.g., limiting access to money, friends, or family), control over reproduction (e.g., forbidding birth control), and victim exploitation (e.g., threat of immigrant deportation (Breiding et al., 2015). The frequency and severity of exposure to IPV can vary throughout different partner relationships. Viewed on a continuum, this may range from an episode that may, or may not, have a lasting impact to chronic and severe episodes that last over a period of years (Niolon, et al., 2017).

In summary, IPV is a social problem that affects many countries worldwide (CDC, 2018). The problem of IPV is continuing in Puerto Rico; statistics show the occurrence of incidents in different parts of the island among victims over the age of ten (Office of the Ombudsman for Women, 2016). More about the stats on women in PR here, is the incidence of IPV rising, remaining unchanged. The occurrence of IPV is related to the presence of multiple risk factors including individual, relationship,
community, and societal factors, all of which can increase the risk for IPV (Niolon, et al., 2017). Also, the consequences and adverse health effects caused by experiencing of IPV have a severe impact on the victim (Niolon, et al., 2017). Multiple investigations have been carried out for the study of intimate partner violence, but the problems are still pervasive. IPV is problematic for the general population including women over age 60, a group that has been neglected in previous studies. The purpose of this study, therefore, was to explore and describe the experiences and perceptions related to the phenomenon of intimate partner violence in women over age 60.

The population of Puerto Rican women over 65 years of age (the age used in data collection) is growing. In 2000, the people in Puerto Rico who were 65 years or older numbered 426,564. By 2012, this number had increased to 550,075 (U.S. Census Bureau, 2012). In 2020, 396,551 women and 297,749 men were age 65 or older, for a total of 694,300 of people age 65 or older (Central Intelligence Agency, 2020). As the population of people over 65 continues to grow, it is likely that incidences of IPV in this age group will increase as well.

As previously discussed, IPV is a significant public health problem that affects many women and has consequences related to health and long-term well-being (Niolon, et al., 2017). It is likely that these consequences and related factors of IPV are affecting Puerto Rican women, especially those over 60 years. Despite the implications of IPV in women over 60, Puerto Rican studies have not focused on older women in particular. One study focused on abuse and maltreatment of older people, (Sánchez, 2007), another on domestic violence in homosexual men and lesbian women (Reyes Rodríguez & Malavé, 2005), and the last on dating violence (Morales Díaz & Rodríguez, 2012).
Studies conducted in other countries have focused on women over 60. These studies provide information about the particular needs of this population. Women over the age of 60 who have experienced partner violence require special health care. Brownell (2015) found that the projects of shelters for domestic violence have not always been successful for older women who have experienced IPV. This is due to a general lack of consensus between shelter programs and the needs of victims. The importance of providing education in service systems, as well as outdated services, senior centers, and adult protective service systems, are considered critical to the effectiveness of shelter services for individuals greater. Furthermore, many older women were not always aware that such services existed in their community (Pathak, Dhairyawan, & Tariq, 2019). Another problem these women face with regard to lack of services is the failure of professionals to identify IPV as occurring in older women, due to existing stereotypes among professional groups that promote the myth that IPV mainly affects younger women (Brossoie & Roberto, 2015).

It is likely that with the increase in the population of people 65 and older, more funds are required for services to meet the needs of these women. Services such as IPV prevention, support of victims, emergency shelter, and healthcare, among others, put a stress on existing services (World Health Organization, 2020). Peterson, Kearns, McIntosh, Estefan, Nicolaidis, McCollister, et al., (2018) found that the estimated lifetime cost of IPV exposure in U.S. is $103,767 for women, $23,414 for men. The cost estimate of IPV exceeds $2.1 trillion in medical costs, $73 billion in criminal justice, $1.3 trillion in lost productivity, and $62 billion in other costs, which includes the loss of property. In 2020, the annual U.S. budget allotted for work with IPV was $590 million,
which is $93 million more than 2019 (National Network to end domestic violence, 2019). Most of the funds received by Puerto Rico for programs related to partner violence come from the United States Federal Government. In 2019, the annual budget for funding of preventive and reactive violence projects was $2,723,083 million, compared to the 2011 budget of $6,769,000 million (US Congress Woman, 2019; Roure, 2011). Puerto Rico is not a state of the U.S, also lacks economic sovereignty; therefore, the residents receive fewer federal benefits than other Americans (Council on Foreign Relations, 2020).

In 2016, Puerto Rico reported nine murders related to IPV, as well as 7,627 IPV cases (6,309 women and 1,318 men). Of these cases, 169 occurred in women over age 60 (Office of the Ombudsman for Women, 2016). This was the last year that statistics reported the age of women exposed to IPV, after this year, only the numbers of cases appear. These cases likely involved previous risk factors, which influenced the occurrence and experience of IPV (Niolon, et al., 2017). Some of the risk factors that characterize older women are the traditional norms and values of gender. Older women tend to be submissive within the family context, to protect privacy rules, and maintain a high degree of loyalty and commitment, despite violence (Bhatia & Soletti, 2019; Band-Winterstein, 2012). In addition to the risk factors, these older women probably had health problems as a result of the IPV experience, since older women who stay in abusive relationships for a long time are more likely to report physical and mental health problems (Stöckl & Penhale, 2015). In addition, many women remain in their homes for lack of an appropriate place to go. Several problems are related to women’s shelters (Blood, 2004): a). They are noisy and chaotic or lack facilities for people with disabilities or reduced mobility; b) Some older women caring for older children or adolescent male
children cannot be accommodated by the shelters; and shelters are not able to provide the intense emotional and practical help to support older women (Blood, 2004). Thus, many older women decide to stay home with the perpetrator of their abuse.

Puerto Rico needs policies that benefit women and organizations devoted to the problem of IPV through prevention and intervention. Prevention strategies include incorporating different community members in protecting battered women, and educational campaigns that emphasize citizen responsibility and victim protection are effective strategies (Roure, 2011). Additionally, shelter services should be improved by adding innovative and accessible services for older women, accommodation projects, and emotional support (Blood, 2004). Many of these options are likely to reduce the experience of IPV in women over age 60. However, it is important to first understand the experience that these Puerto Rican women over 60, and their perceptions regarding IPV, in order to offer the services best suited to meet their specific needs. For example, an understanding of the IPV experiences for women over 60 may provide valuable information to health professionals as they strive to deliver sensitive and informed health care to older women. This new knowledge about the experience of IPV in older women will help health care providers recognize abuse in this population and refer to appropriate services. The new knowledge gained through this research may be used for creating new proposals and policy interventions for older women in Puerto Rico.
Research Aims

1. To explore the experiences of IPV in a sample of Puerto Rican women over 60 years of age.

2. To consider the effects of IPV on women’s health.

Definition of Terms

The following terms were used throughout this proposal and are defined here to provide clarity and consistency:

*Abuse:* Maltreatment that includes several types of violence: physical, sexual, psychological, and emotional.

*Intimate partner violence (IPV)*: Violence that occurs between two people in an intimate, often sexual, relationship and includes current and former spouses, as well as dating partners. IPV exists along a continuum from a single episode of violence to ongoing battering (CDC, 2016) and describes physical, sexual, emotional, or psychological harm by a current or former partner or spouse.

*Physical violence:* The intentional use of physical force. This can lead to death, disability, injury, or harm.

*Sexual violence:* Abusive sexual contact without the person’s consent.

*Psychological violence:* Act of controlling and threatening a person with the intent of causing embarrassment or feelings of inferiority.

*Older Puerto Rican women:* For the purpose of this study, this term is defined as women over the age of 60 who live in Puerto Rico.

*Disclosure of abuse:* The expression or verbalization of the abuse with another person (e.g., family, friends, neighbors, or health professionals).
Significance

In a comprehensive list of national health objectives, with the ultimate goal of reducing disparities in health, violence is listed as one of the ten leading health indicators of Healthy People 2020 (U.S. Department of Health and Human Services, 2000). One of the determinants related to violence is IPV (U.S. Department of Health and Human Services, 2000). More women than men experience IPV. During their lifetime in U.S., about 43.6 million of women experienced assaults and rape by their partners (Smith, Zhang, Basile, Merrick, Wang, Kresnow, et al., 2015). The increase in the statistics of IPV, and the health consequences in women, led to their selection as participants in this study, with special focus on women over age 60.

Three main reasons exist for the selection of this research topic. First, data are lacking related to the experience of IPV in women over 60 years of age in Puerto Rico. This lack of knowledge is significant because the experiences of older women are likely quite different than younger women due to developmental differences and life stage. Older women are often invisible in IPV research and are regularly overlooked in studies of IPV (Bhatia & Soletti, 2019). The incidence of IPV among older women has been obscured by its inclusion under “elder abuse,” which focuses on abuse of elders by adult children and caregivers, as opposed to abuse by an intimate partner (Bhatia & Soletti, 2019; Sanchez, 2007). Therefore, this study is vital to revealing new knowledge specifically about the experiences of women over 60 who have suffered from IPV in Puerto Rico.

The second reason for selecting this area of research is related to the increasing population of people over 60. In 2020, the total population of Puerto Rico was 3,189,068;
of these, 1,682,192 were women (Central Intelligence Agency, 2020). The structure of
the population of Puerto Rico has become one where people over 60 predominate, with
an increase of this age group from 11.2% in 2000 to 15.2% in 2011 (Rodríguez,
Geerman, & Pesante, 2012). In 2000, 12.2% of women were 65 and older, and by 2011
that total increased to 16.5% (Rodríguez, et al., 2012). With our increasing elderly
population, it is likely that the incidence of IPV in this population will also increase.
Furthermore, the number of women exposed to IPV compared to men has also increased.
This increase requires and stresses the importance of including specific research studies
about IPV in women over 60 the purpose of this study.

The third reason related to the selection of this topic is the need to develop
knowledge of IPV among older women in order to improve the nursing care of victims, to
which this study aims to contribute. It will also serve as the basis for the development of
continued research of IPV in older women. In addition, the data generated may help to
promote new public policies and nursing interventions that focus on prevention and
management of partner violence against older women.

The issue of IPV is accompanied by a number of interesting points to investigate.
Several studies related to this issue have been conducted, but few have focused on the
experience of older women. Prior research has focused mainly on the effects of IPV on
physical and psychological health, risk factors, and services offered. This qualitative
research study brings into focus the experiences and perceptions of women over age 60
who have undergone this sorry phenomenon. These experiences provide new knowledge
to nurses and other healthcare professionals, which may influence the practice, care, and
improvement of services for this population. In the next chapter, a revision of several
investigations related to cultural factors and IPV, experience of abuse, perceived impact, and ability to seek healthcare will be discussed.
CHAPTER 2

REVIEW OF LITERATURE

Introduction

The purpose of this study was to explore and describe the experiences and perceptions related to the phenomenon of intimate partner violence in Puerto Rican women 60 years or older. Toward that purpose, this chapter presents a review of literature concerning the following topics: (a) the history and culture of Puerto Rico; (b) Puerto Rican cultural values (familism, “machismo,” and “Marianismo”); (c) research to date about older women and IPV; (d) the impact of IPV on the physical, psychological, and financial aspects of women’s lives; and (e) the healthcare response to victims of IPV. Individuals cannot be separated from their cultural context; therefore, it is important when studying IPV to understand its influences and processes related to the culture. IPV is a public health problem that affects all populations of socioeconomic classes and cultures, and it can be devastating for Hispanic women who do not have access to social services (Alvarez & Fedock, 2018; Gonzalez-Guarda, et al., 2013). Several studies have found that Hispanics are at higher risk for IPV than other racial/ethnic groups (Stockman, Hayashi, & Campbell, 2015; Gonzalez-Guarda et al., 2013). The risk factors associated with IPV vary by ethnicity and type of violence (Petrosky, Blair, Betz, Fowler, Jack, & Lyons, 2017). Ethnic differences in the occurrence of IPV may be partially mitigated by socioeconomic characteristics (Alvarez & Fedock, 2018). Ethnic differences in the prevalence of IPV and its consequences suggest that significant health disparities exist among White, Black, and Hispanic populations (Stockman, et al., 2015).
The History and Culture of Puerto Rico

Puerto Rico is one of the world’s oldest colonies (Montesinos, et al., 2002). In 1809, the island of Puerto Rico was recognized as a province of Spain (Montesinos et al., 2002). In 1897, after many years of political unrest, Spain granted Puerto Rico significant self-governance through the adoption of the Autonomic Charter, allowing Puerto Rico to enter free trade with the United States (US; Montesinos et al., 2002). In 1898, Puerto Rico became a territory of the US, which has continued for over 100 years (Montesinos et al., 2002). This territorial designation provides the following rights to the people of Puerto Rico: (a) US citizenship, (b) eligibility to serve in the US armed forces, (c) the right to reside freely in the US, (d) eligibility to receive federal grants, (e) Social Security benefits in Puerto Rico a portion of the payroll taxes paid by workers and their employers covers most Medicare and Social Security fees (Social Security Administration, 2016)), and (f) to send a Resident Commissioner to participate, but not vote, in the US Congress (Encyclopedia.com, 2019).

The capitalist immersion after the Second World War brought modernization strategies that became a model for the new emerging international division of labor. US President Franklin D. Roosevelt launched the Reconstruction Administration of Puerto Rico, which provided agricultural development, public works, and electrification of the island (Montesinos et al., 2002). The transformation of political and economic areas that ensued brought changes in women’s status with respect to reproduction and the family, which challenged the most traditional definitions of femininity on the island. In 1951, the island obtained the right to establish a government under its own constitution, and in 1952 it was declared a free associated semi-autonomous territory of the US (Montesinos

16
et al., 2002). After this, the island had a significant improvement in its economic
development and attracted manufacturing plants from companies based in the continental
US (Montesinos et al., 2002). Recently the US, declared Puerto Rico a territory and
recognized that it never became “The Commonwealth of Puerto Rico” in English and “El
Estado Libre Asociado de Puerto Rico” in Spanish (Supreme Court of the US, 2016).

The development and improvement of public health in Puerto Rico began in the
20th Century (Maldonado, 2015). This progress was related to access to preventive and
curative measures and to the infrastructure of public health (Maldonado, 2015). The
socioeconomic aspect, improved infrastructure, and vaccines were the bases for
improving public health in Puerto Rico. Malaria, anemia, and tuberculosis had been
public health problems in the 20th Century (Rigau-Pérez, 2000). The public health laws,
medical advances, and improved quality of life were a few factors that significantly
reduced the rates of infectious and parasitic diseases, as well as the access Puerto Rican
residents gained to medical and hospital services (Lex Juris Puerto Rico, 2002). In 2013,
the 12 leading causes of death among Puerto Ricans were cancer, heart disease, diabetes
mellitus, Alzheimer's disease, cerebrovascular disease, accident, lung disease, nephritis,
homicide, septicemia, pneumonia, and influenza, and, the last, hypertension. Within the
accident and homicide categories are cases of domestic violence (Ríus, Sánchez, Morales,
& Torres, 2015).

Between January and December 2019, the total number of reported IPV incidents
was 6,725. Ten deaths were attributed to IPV in that same period (Office of the
Ombudsman for Women, 2019). IPV continues to be a significant problem in Puerto Rico
(Report of the Planning Board Governor, 2013). Recognizing that one of the most
complex problems on the island of Puerto Rico was IPV, the government developed legislation to help prevent and intervene to end it. The Domestic Violence Act, was developed and established in 1989, for the purpose of providing protection and assistance to victims, alternatives for the rehabilitation of offenders, and strategies for the prevention of IPV (Lex Juris, 2019).

Puerto Rican Cultural Values

The discussion of cultural aspects helps us to understand how gender, society, religion, and sexuality influence the problem of IPV. Triandis (1995) has defined culture as “a pattern characterized by shared beliefs, attitudes, norms, roles and values that are organized around a theme and that can be found in certain geographic regions during a particular historic period” (p. 43). Puerto Rican cultural norms about IPV can be seen in the way people talk about IPV; e.g., expressions such as “¿El qué dirán? ("What will people say?") or “La ropa sucia se lava en casa” ("Laundry is washed at home") (Goldberg, Hokoda, & Ramos-Lira, 2007). These cultural norms encourage women to keep silent and maintain the domestic violence problem in the privacy of their homes.

Puerto Rican people have a number of cultural values that may present risks, or protective factors, for IPV. These cultural values will be discussed below: familism, "machismo" and “marianismo.”

Familism is one of the most important values for Latinos (Arredondo, Gallardo-Cooper, Delgado-Romero, & Zapata, 2015). Familism is defined as cultural responsibility and sense of duty to family members (Mogro-Wilson, Rojas, Haynes, 2016). Familism has both negative and positive aspects (Mogro-Wilson et. al., 2016; Gonzalez-Guarda, et al., 2013). The union of family members and the support provided to individuals in the
family are protective factors against IPV (Gonzalez-Guarda, et al., 2013). Latinos see their family as a source of emotional support, both structural and material (Valdivieso-Mora, Peet, Garnier-Villarreal, Salazar-Villanea, & Johnson, 2016). A negative aspect of familism is to keep the family together and not seek help outside the home (Gonzalez-Guarda, et al., 2013). Another negative factor is that victims of IPV may try to avoid bringing shame upon the family by keeping the abuse a secret (Gonzalez-Guarda, et al., 2013). In this way, unreported abuse is allowed to continue (Gonzalez-Guarda, et al., 2013).

Men, especially Latin Americans, are commonly described as "machistas" and are considered “machismo.” “Machismo” is a term that was popularized in the social literature of the 1950s and 1960s, having been originally introduced as a Latin American phenomenon (Ramirez, 1999). The term is associated with male behaviors to which negative qualities are attributed, such as “the sum total of simultaneous brutality, arrogance, and submissiveness” (De Jesús, 1977, p. 37). Machismo is a traditional gender role that promotes male dominance (Nuñez, González, Talavera, Sánchez-Johnsen, Roesch, Davis, et al., 2016). The aspects of “machismo” are both negative and positive. On the positive side, men are characterized as leaders who make decisions relative to family benefits, such as finances. Also, they support and are sensitive with their partner, help with housework, and care for the children (Gonzalez-Guarda et al., 2013). Yet men who participate in household tasks are perceived as weak by the same society. This role confusion facilitates the prevalence and acceptance of IPV in families (Gonzalez-Guarda et al., 2013). On the other hand, the negative aspect of machismo includes, domination of women, sexism, aggression, and restricted emotional expression (Nuñez, et al., 2016).
Catholicism represents another traditional value, Marianism, which focuses on the woman having the same virtues as the Virgin Mary. These virtues include caretaking, duty, self-sacrifice, honor, passivity, and sexual morality (Hussain, Leija, Lewis, & Sanchez, 2015). Marianism is related to the reverence that the Roman Catholic Church has for the Virgin Mary. It is also related to the submission of women to men (Gonzalez-Guarda et al., 2013). Expectations are that the unmarried woman remain chaste before marriage (Nuñez, et. al., 2016). It is also expected that religious and cultural traditions will be transmitted to succeeding generations of women (Nuñez, et. al., 2016). The negative aspects that characterize Marianism are self-sacrifice and a passive role in the relationship with her husband (Hussain, et al., 2015). Moreover, another characteristic of Marianism is that sex is for procreation and not to cause pleasure (Hussain et al., 2015).

The core concept of Marianism is the self-sacrifice; therefore, the tolerance of pain and suffering can be interpreted as a symbol of strength (D’Alonzo, 2012).

**Research to Date About Older Women and IPV**

The older woman living in an IPV relationship throughout her life experiences an unhappy marriage (Hawkins & Booth, 2005). Violence feeds the long-term relationship. These relationships, in older adults, are experienced as empty and unsatisfactory, with an inability to overcome the problems (Band-Winterstein, 2006). Sometimes, the abuse of these women originated from their childhood years (McMahon, Hoertel, Wall, Okuda, Limosin, & Blanco, 2015). Childhood experiences of violence include the testimony of violence initiated by the father, corporal punishment, and sexual abuse—factors associated with IPV (Fulu, Miedema, Roselli, McCook, Chan, Haardörfer, et al., 2017). The experience of abuse is usually carried to a woman’s next stage with her new family.
and intimate relationship (Huecker & Smock, 2020). Older women experience not only physical or sexual violence, but often they report different stories of abuse, because one form of abuse is often followed by another, resulting in a chronic pattern of abuse (Bathia, & Soletti, 2019). The victimization is part of her life for many years (Tetterton & Farnsworth, 2011). For older women, the memory of the violence remains a lifetime experience.

Abused older women cling to traditional values regarding gender roles and tend to be submissive in the family context, in addition to maintaining the privacy rules in the home (Sikweyiya, Addo-Lartey, Alangea, Dako-Gyeke, Chirwa, Coker-Appiah, et al., 2020; McGarry & Bowden, 2017). The beliefs and cultural values encourage Puerto Rican women to keep silent and maintain the abusive relationship in secret (Goldberg et al., 2007). The silence and family privacy are risk factors for these older women: It is known that these beliefs strongly influence the reporting of IPV because doing so could put the women at risk of further violence, or because they are simply ignorant of their rights. This is in addition to the perceived need to keep this information private from caregivers, or anyone else (Fisher, Zink, & Regan, 2011). Older women who are exposed to IPV, experience a combination of loneliness and violence, which leads them to feel a fear of abandonment (Band-Winterstein, 2012). This experience of IPV in older women can lead to insecurity and high levels of self-doubt (Tetterton & Farnsworth, 2011).

The older women who experience IPV may be more vulnerable than younger women due to illness and the aging process. Eisikovits and Band-Winterstein (2015) iterate their hardship in detail as follows: These older women may feel less beautiful and so their suffering is deeper, presenting different emotions. Their treatment, such as ageist
and sexual insults, is experienced as psychological abuse. They expect abuse from their partner and feel like marionettes. Dependency, low self-image, and abuse create a unique experience characterized by suffering and static spatial experiences in which violence enters and is there to stay. These older women express feelings of anger, emptiness, loss, and injustice (Eisikovits & Band-Winterstein, 2015).

Frustration occurs in the older women who experience IPV, creating a routine of absence and a sense of injustice inherent in emotional distress. Older women may perceive violence as more serious and harmful than their younger counterparts, since a cumulative effect over time may decrease their levels of tolerance and the ability to cope (Band-Winterstein & Eisikovits, 2009). Women who experience IPV are often able to develop emotionally focused strategies or adaptation to cope with a continuous abuse (Zink, Jacobson, Regan, Fisher, & Pabst, 2006). These strategies or adaptation techniques can be unhealthy, such as substance use (Tetterton & Farnsworth, 2011).

The Impact of IPV

IPV can lead to health problems that affect the welfare of older women (El-Serag & Thurston, 2020). The experience of IPV in women of all ages may result in negative effects on physical and psychological health. Older women who stay longer in the IPV relationship tend to report more mental and physical health problems (Stockl & Penhale, 2015).

Physical health

The abused older women experience 25 or more episodes of physical violence or controlling behavior in their lifetime (Davies, Ford-Gilboe, Willson, Varcoe, Wuest, Campbell, et al., 2015). The controlling behavior was further associated with health
problems such as allergies and weight problems (Stöckl & Penhale, 2015). The constant stress, and social tensions created by IPV, can impair the physical health of women (Khodabakhshi-Koolaee, Bagherian, & Rahmatizadeh, 2018). Some adverse effects include, disability, such as having difficulty walking, difficulty with daily activities, pain, or memory loss, as well as physical symptoms such as dizziness and vaginal discharge (Hegarty, O’Doherty, Chondros, Valpied, Taft, Astbury, et. al., 2013; Gibson, et.al, 2019; Chandan, et.al.,2019).

Sanz-Barbero, Barón and Vives-Cases, 2019 reported that women who have experienced IPV are more likely to report poor health. The different types of abuse are related to the problems and conditions of mental and physical health, and they can occur in the short or long term (Costa, & Botelheiro, 2020). Older women who have experienced IPV have reported various health conditions such as depression, anxiety, fear, gastrointestinal problems, pelvic problems, among others (Fraga, Soares, Melchiorre, Barros, Eslami, Ioannidi-Kapolou, et al., 2017; Stöckl & Penhale, 2015). Other conditions associated with IPV experiences are chronic fatigue, fibromyalgia, and high blood pressure, among others (Chandan, et. al. 2019; El-Serag, et. al., 2020).

**Psychological health**

The experience of IPV in older women is associated with poor mental health (Bhatia & Soletti., 2019). Women with mental problems are vulnerable to experiencing IPV (Khalifeh, Oram, Trevillion, Johnson, & Howard, 2015). The experience of IPV also brings psychological health problems, such as significantly more emotional distress, suicidal thoughts, and suicide attempts compared to non-abused women (Niolon, et al., 2017; Baloushah, et al., 2019). Other factors affecting older women are the symptoms of
post-traumatic stress that can become severe with life events such as retirement and death of a loved one (Sormanti & Shibusawa, 2008).

Exposure to IPV makes older women more likely to have psychological problems such as panic attacks and acute anxiety (McGarry, Simpson, & Hinchliff-Smith, 2011). Some of the specific effects of IPV in this population include long-term trauma, along with mental health problems such as depression, anxiety, and drug abuse (Baloushah, et al., 2019). The negative aspects related to the isolation of emotions, loss of identity, as well as tension and stress that influence health and cause problems in the relationship (McGarry & Bowden, 2017; Khodabakhshi-Koolaee, et al., 2018).

The effect of chronic and childhood abuse

Abuse during childhood may affect the incidence of abuse in adulthood. Scriver, Mears, and Wallace (2013) found that older women sexually assaulted as adults were more likely to have experienced isolated attacks compared to those who had been assaulted in childhood, who were more likely to suffer ….. Older women who experience sexual violence share certain similar characteristics compared to other age groups, but are presented as a group of survivors with differing experiences and needs of the general population (Scriver et al., 2013).

All these factors can be linked with the older woman’s experience of IPV and adverse health outcomes caused directly through injuries resulting from violent acts, and indirectly through increased stress, reduced mobility, and limited access to resources and healthcare (Stöckl & Penhale 2015).

Financial Aspects

Low socioeconomic status is associated with an increased risk of experiencing
IPV (CDC, 2019). Women over 65 are at increased risk of violence if their partner had a higher level of education or occupational training than they did (Stöckl, Watts, & Penhale, 2012). Lack of economic resources and dependence on partners represent barriers to leave an abusive relationship and to report abuse (Sanders, 2015). Furthermore, the socialization of older women and their current economic situations may affect the willingness and ability to disclose abuse (Bhatia & Soletti, 2019).

The financial and emotional risks of leaving a relationship in older women are amplified by the increased likelihood of financial dependence, profound social neighborhood ties, and strong feelings of attachment to another; e.g., home, community (Simmons, Farrar, Frazer, & Thompson, 2011). The abused older woman may fear the absence of known sources of support, which leads to a dependency on her partner and therefore additional reluctance to expose the abuse (Stöckl & Penhale, 2015). Experiences and positive memories make women stay in the relationship despite the abusive elements (Beaulaurier, Seff, & Newman, 2008).

Most Puerto Rican women have worked at some time in their lives, however upon reaching an older age, they may find they no longer have the skills needed to secure a job that pays a living wage. These women may decide to stay in an abusive relationship rather than lower their standard of living, possibly lives in poverty, lose their home, or lose their health insurance coverage (Rennison & Rand, 2003). This is particularly important since they are at an age when health insurance is especially important (Rennison & Rand, 2003).
The Healthcare Response to Victims of IPV

Health providers should routinely screen older women to identify IPV (McGarry & Bowden, 2017), since abuse can start late in life, IPV may have occurred in a previous relationship, or IPV may persist throughout a woman’s life (McGarry & Bowden, 2017). Importantly, few studies have focused on routine screening and detection of cases in older women (McGarry et al., 2011). Women who experience abuse for many years may not be capable of disclosing the IPV during the follow-up visit with the healthcare provider and do not feel able to disclose the abuse with others (Dichter, Makaroun, Tuepker, True, Montgomery, & Iverson, 2020). Healthcare providers should be alert to intimate partner violence as a problem for older women and should know that they are often reluctant to disclose such information (McGarry & Bowden, 2017).

Bhatia & Soletti (2019) suggest that failure to report abuse can lead to emotional isolation and impotence, exacerbating the long-term impact on self-esteem and physical health of older women. Older women are more likely to report a high number of health conditions, so they receive care more frequently (Stöckl & Penhale, 2015). Therefore, health providers have more opportunities to ask if they are in an abusive relationship (Sood, Novotny, Faubion, Thielen, Shuster, Kuhle, et. al., 2016). As women have a longer life, training of health professionals to meet the needs of abused older women will become more imperative (McGarry & Bowden, 2017). In addition, it is important to improve the services and effectiveness, provision, and support of care, designed specifically for IPV for the older women (McGarry & Bowden, 2017).

According to the literature, there are few services or programs designed to meet the specific needs of abused elderly women (Brownell, 2015). The lack of attention to the
problem of IPV in older women has resulted in limited detection, which is related to the lack of appropriate detection instruments for this population and limited community resources (Simmons & Scotese, 2010).

**Barriers to Seeking Care**

Beaulaurier, Seff, Newman and Dunlop (2007) conducted a study involving older women who experienced IPV to determine the existence of barriers to seeking help. They found that although there are support services for older women, the women were not always aware of the existence of services. Beaulaurier and colleagues (2007) also found that although the services are available, they were inappropriate and did not recognize the needs of older women. Nurses with personal experiences of IPV, were found to be more empathetic and were more able to identify gaps in service delivery compared to nurses who did not have personal exposure to IPV (Haggblom and Moller, 2006). Physicians in New Zealand had difficulty recognizing family abuse in a family where the problem was not evident (Miller & Jaye, 2007). Willingness of older patients to disclose abuse to health care professional was related to the perception of loyalty (Wong, Jonge, Wester, Mol, Romkens, & Lagro-Janssen, 2006). For example, an important barrier to reporting partner abuse was found to exist if the health care provider also attended the abusive partner.

A descriptive study with 527 nurses and 238 physician in Ontario, Canada found that 61.5% of nurse and 58.0% of physician have reported that they have no specific training in IPV issues (Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012). This is an important point because the reports of IPV often come from physician and nurses
(Beynon et.al, 2012). Factors such as lack of time, lack of training, cultural practices, lack of quality of resources that a patient can refer to once abuse is determined, and discomfort with the issue of abuse may be possible barriers to implementing protocols in older women. Training and professional experience are associated with feelings of preparation and self-confidence that help health professionals to feel more control and manage when working with women exposed to IPV (Beynon et.al, 2012).

The literature has highlighted a number of barriers for report of IPV among older women. Some barriers to report of IPV are related to the dependence of partner, stigma, shame, and social isolation (Dichter et. al., 2020). Many women are afraid of disclosing problems related to stigma or judgment to healthcare providers (Dichter et. al., 2020). Other potential obstacles to reporting abuse are dependence on their partner and the traditional attitudes of marriage and gender roles (Murphy, Ellsberg, & Contreras-Urbina, 2020; Dichter et. al., 2020).

It is important to consider several points when talking about the disclosure of abuse in older women. Beaulaurier et al. (2008) conducted a qualitative study of 134 women between the ages of 45 and 85 and found several barriers to IPV disclosure. Among the internal barriers is fear that their partner might be put in prison or removed from the home. The women also described feelings of shame and guilt about reporting the abuse, a reflection of the older women’s socialization to be passive and believed that divorce was not an option (Beaulaurier et al., 2008). External barriers included fear of reporting abuse to family members, fear of poor response and poor support (Beaulaurier et al., 2008). Another theme identified was the connection to the clergy or church. In most cases, the clergy encouraged a woman to stay with the abuser, and offered little or
no practical assistance or referrals to appropriate agencies (Beaulaurier et al., 2008). In the judicial system, the actions of protection orders or mandatory classes of anger management were seen as ineffective and exacerbating the anger of the aggressor (Beaulaurier et al., 2008). Regarding community resources, many women indicated they did not know where to get help, they did not know that services to victims of IPV were available, and that prevention campaigns of partner violence were not directed to older women (Beaulaurier et al., 2008).

**Facilitators to Seeking Care**

Among recommendations for older women exposed to IPV are the need for discreet information that is available for victims in public places, to improve professional sensitivity to the needs of victims under duress, and improved shelter and housing options (Roberto, Brossoie, McPherson, Pulsifer, and Brown, 2013). Moreover, recommendations were made for further support monitoring through calls, support groups, or home visits (Roberto et al., 2013). Other researchers recommend additional effective interventions in working with older women exposed to IPV. Among these, are welcoming and engaging the encounters with health care provider who are knowledgeable about the fears and concerns of abused women (Dichter et. al., 2020). Furthermore, health care providers must be educated to encourage and support the narrated history itself, listening attentively without judging the stories of the woman (Dichter et. al., 2020). Assistance in the empowerment process comes from within, so the role of the consultant is to listen, support, and provide adequate information. In addition, the choices made by the woman must be respected, and the value displayed in asking for help and safety must be recognized (Dichter et. al., 2020; McGarry & Bowden, 2017).
Summary

This chapter reviewed the literature related to the experience of older women who have suffered IPV. The five areas of review included (a) the history and culture of Puerto Rico; (b) Puerto Rican cultural values (familism, “machismo,” and “Marianismo”); (c) research to date about older women and IPV; (d) the impact of IPV on the physical, psychological, and financial aspects of women’s lives; and (e) the healthcare response to victims of IPV. It is important to note the mix of cultures in the history of Puerto Rico, such as Spain and the US, that have influenced the values and customs of Puerto Ricans. Moreover, it is important to recognize that cultural values can hold negative factors that influence IPV occurrence. This does not occur in all cultural values; e.g., familismo is a protective factor as it provides family support for individuals and reduces the risk of exposure to IPV.

The arrival of the US to Puerto Rico improved the island’s 20th Century political and economic transformation and brought changes in the status of women in relation to reproduction and family. The 20th Century was also the time when development and strategies to improve public health began in Puerto Rico. This progress led to the inclusion of preventive and curative measure for health management. Recognizing that IPV is a public health problem, Puerto Rico developed the Domestic Violence Act, which provides assistance and protection to victims of IPV.

In the area of older women and IPV, the literature reveals that experience with violence and abuse can begin in childhood and be part of the lives of women for many years. According to researchers, IPV exposure may be related to traditional values, gender roles, and privacy rules. Constant exposure to IPV causes older women to have
negative health effects, including physical and psychological problems. In addition to health problems, the economic factor and dependency on their partner is a risk factor for IPV exposure.

Relative to the disclosure of IPV by older women, their reluctance to disclose abuse is common. Researchers have found several barriers to disclosure of IPV, among which are the consequences of reporting abuse (increased anger of the aggressor), traditional gender roles or norms, and fear, among others. Although older women make many visits to their healthcare providers, the providers are sometimes not able to identify the IPV. Investigations revealed that this may be associated with a lack of training with respect to IPV. This then affects the application of appropriate tools for the detection of IPV, limited knowledge of resources, and poor management when working with this population. Researchers recommend that health professionals use effective interventions for the management of IPV, bring support, using communication tools, and provide adequate information.

In the next chapter, the methodology of this study will be discussed, including the design, the characteristics of participants, settings, data collection, data collection procedures, summary of findings, interpretation of findings, limitations, and the plan for human subjects.
RESEARCH TO THEORY

The research study builds nursing knowledge through research that may be used to form future theory (Meleis, 2012). Hermeneutic phenomenology is based on the philosophy of interpretation of experiences. The concepts that form the basis of phenomenology are the human, social, political, and cultural context in which a person’s experience is used to attempt to make sense of the world. These experiences provide insight into an individual’s unique life and the world as they perceive it. The new knowledge obtained through phenomenology may be used to develop a middle-range theory about the health among older women who experience IPV. This newly developed theory may then be tested through quantitative approaches to research, further expanding nursing knowledge.
CHAPTER 3

METHODOLOGY

Introduction

To best study the experiences of IPV among older Puerto Rican women, a phenomenology approach was conducted. This method was used to guide an exploration of the experiences related to IPV among Puerto Rican women over age 60. Qualitative research is the study of meaning among individuals or groups who experience social or human problems (Creswell, 2017). There has been little investigation of IPV among populations of older women (Brand, 1997; Penhale, 2005; Sormanti & Shibusawa, 2008) and few qualitative studies have sought to understand the meaning of living with IPV (Winterstein & Eisikovits 2005, Band-Winterstein and Eisikovits (2009; 2010); Eisikovits & Band-Winterstein, 2015; Stöckl & Penhale, 2015; McGarry & Bowden, 2017; Bhatia & Soletti, 2019; Dichter et. al., 2020). Thus, the experiences of IPV among older women remain unknown and further investigation is needed to understand this phenomenon if nurses are expected to provide informed care to this population. The hermeneutical phenomenology approach helps the researcher gain a deep understanding of cultural influence and age related with IPV. Only older women who have experienced IPV are able to give meaning to their experience.

Purpose

The purpose of this study was to explore and describe the experiences and perceptions related to the phenomenon of Intimate Partner Violence among Puerto Rican women over age 60.
Research Aims

1. To explore the experiences of IPV in a sample of Puerto Rican women over 60 years of age.

2. To consider the effects of IPV on women’s health.

Design

In this phenomenological study design, in-depth interviews were used to explore and describe the experiences and perceptions of Puerto Rican women over 60 years of age who have experienced Intimate Partner Violence. Phenomenology is a human science approach rooted in philosophy (Van Manen, 1990). Phenomenology is “the science of essence of consciousness” that reveals humans’ reality and personal meaning (Husserl, 1952, p. 174). Phenomenology is used to understand human experiences (Husserl, 1952). Indeed, phenomenological study describes the meaning of lived experiences of a phenomenon through the perspectives of participants (Van Manen, 1990). The main purpose of phenomenology is to explore a deep understanding of the nature or meaning of experiences (Van Manen, 1990).

There are two main approaches that guide the majority of published phenomenological studies in the field of nursing: phenomenology, and hermeneutic phenomenology (Laverty, 2003). Husserl, the pioneer of phenomenology, believed that the researcher much bracket any prepositions of the phenomenon in order to uncover the essentials, or the universal truth, of a phenomenon. However, later hermeneutic phenomenology erased the idea that the researcher can separate past experiences from the research, instead asserting that research experiences and participant experiences co-exist and, in fact, are unable to exist without the other. From this perspective, Heidegger saw
bracketing as impossible, as one cannot stand outside the pre-understandings and historicality of one’s experience (Heidegger, 1927/1962).

Heidegger developed the hermeneutic phenomenology based on a philosophy of interpretation (Creswell, 2017). Phenomenology “is Hermeneutic in the primordial signification of this word, where it designates this business of interpreting” (Heidegger, 1962, p.37). Heidegger (1977) explained the essence of a phenomenon as “the way in which it remains through time as what it is (p. 3)”. This Hermeneutic approach moves beyond the descriptions of main concepts of the experience and seeks the meaning in the everyday occurrence (Lopez & Willis, 2004). Heidegger pointed out that experience is already in the world and that it is not a thing, but a movement in the world (Moules, 2002). Therefore, understanding is deeply rooted in ontological composition of Da-sein, care, existence, temporality, and being (Heidegger, 1996). Da-sein (a human way of being in the world) is a concept related to hermeneutic phenomenology. This concept includes the relation with the social, political and cultural context (Campbell, 2001). The main goal of this approach is the identification of participant’s meanings through the researcher’s understanding of the participant’s experiences through participant interviews and data obtained from others source (Wojnar & Swanson, 2007). For the purposes of this research, it is important to understand the meaning older women in Puerto Rico give to the IPV experience. Hermeneutic phenomenological methodology was selected because it affords:

• A focus on detailed aspects of the lived experiences (Laverty, 2003).
• An interpretive narrative of the description of the subjective experiences of individuals in order to grasp the essence of the phenomenon (Kafle, 2011).

• A method to explore and understand the histories related with the lived experiences of persons (Langdridge, 2007).

Few studies have been done with older women experiencing IPV using the phenomenological approach. One such study explored how intimate partner violence is experienced in women between 60 and 84 years of age, and how the violence changes throughout the life span (Band-Winterstein & Eisikovits, 2009). Analysis of the data from this study revealed that suffering and terror were the result of long-term entrapment in a common history fed by cumulative events (Band-Winterstein & Eisikovits, 2009). In addition, for these women, the experiences of IPV acts as a barricade between past, present and future because their experience of the violence is as if it was happening in the present, even when it may have occurred years before.

In another study conducted by Band-Winterstein and Eisikovits (2010), conceptualization of violence against older battered women over a five-year period was examined using concepts of intentionality of the body, time and space to describe the participant’s lived experiences of IPV. By conducting 25 in-depth and semi-structured interviews with Israeli women from 60 to 84 years of age, the researchers found that these women perceive violence as a chronic illness that affects their bodies (elevating their blood pressure, physically changing it). The passing of time is seen through lost opportunities because of the choices they made while they felt stuck in the place they were, perceived as a lack of freedom.
Target Population

In depth-semi-structured interviews were conducted with Puerto Rican women who were over 60 years of age and who had experienced Intimate Partner Violence. Six participants were recruited and interviewed until saturation was achieved (Morse, 2000; Guest, Bunce, & Johnson, 2006). Saturation was achieved when the same information is repeated by participants and when no new information is found (O'Reilly & Parker, 2012; Walker, 2012; Guest, et. al., 2006). Qualitative study samples are usually small in size (Munhall, 2012). There are three reasons for this, a) if the data is correctly interpreted, there will come a point where very little new information is obtained from each additional participant, b) the purpose of a qualitative study is not to determine incidence or prevalence of the phenomenon under study, and c) in-depth interviews provide rich detail about each participant’s experience (Ritchie, Lewis, Nicholls, & Ormston, 2003).

Settings

Initially, two centers were selected for data collection, located in the mountainous area of Puerto Rico, in the city of Aibonito. One is called "Envejecer en Armonía", a non-profit organization serving mostly older women from disadvantages communities. Services include creative, participatory, and educational workshops about violence and abuse prevention and workshops to strengthen self-reliance.

The second center that was initially selected was "Casa Pensamiento de Mujer del Centro", a non-profit organization providing services to women victims of IPV, stalking, sexual assault and /or rape. Support services and counseling, legal representation, psychological services, support groups, workshops and lectures for the community are also provided to the women.
The time of data collection was extended due to hurricanes in 2017 in Puerto Rico. After Hurricane Maria in September 2017, the Puerto Rican community faced various difficulties, some of which were the loss of homes, lack of food and water, and power outage. As a result, when “Envejecer en Armonía” and "Casa Pensamiento de Mujer del Centro” were contacted again in February 2018, they expressed that they had limited working hours as their facilities and had no electricity. Visiting their facilities in April, they indicated that the population that this study focused on, decreased, and that they only had participants below the age of 60 making them not qualifiable for the interviews; consequently, another center was contacted. Meeting the criteria of this study, a center that receives victims of psychological trauma (The Psychotraumatology Institute) and Dr. Lorna Oyola’s general medicine office were selected.

The Psychotraumatology Institute services focused on the multidisciplinary intervention of victims that suffer from psychological trauma by implementing the transformation of these experiences into encounters that carry a constructive meaning, encouraging their stability; moreover, they aim to empower and help the victims to reinstate themselves in society. Additionally, some of the other services that they provide are guidance on available aids, support groups for victims of domestic violence, social work, counseling, psychotherapy, emergency assistance, and legal orientation.

Dr. Lorna Oyola’s general medicine office aids in the intervention of various types of populations. In many of the cases they receive, their patients have been victims of abuse. This facility works directly with the education and help of people who have experienced any form of abuse no matter the age group that they belong to. Furthermore,
they provide services to elderly women who have been exposed to IPV, and refer patients to other physician, specialist, or agencies.

**Inclusion/Exclusion Criteria**

To participate in this study, women met the following inclusion criteria: 1) Puerto Rican women age 60 or older who have experienced intimate partner violence involving a man. 2) Women who speak Spanish and are able to understand what will be expected of them as a participant, and are able to give informed consent. Exclusion criteria include: 1) Participants under 60 years of age 2) Women who are injured or ill at the moment of recruitment. 3) Those who are not able to provide consent because they under the influence of a substance or are cognitively impaired, and 4) Women whose IPV relationship involves another woman will be excluded since this would represent a different phenomenon. IPV among women in intimate relationship requires a separate study.

**Interviews process**

Data collection: In-depth phenomenological interview

**Recruitment process:** Participants were recruited through flyers (Appendix A) that were delivered to the administrators of the centers, posted on bulletin boards, and left in waiting and common area rooms. These were also delivered to potential participants by the center administrator. Women who were interested in participating in the study contacted the researcher via email and telephone. In addition, when the participant agreed, personal contact information was left with the administrator of the center in order to be contacted and informed of the day and time that was most convenient for them.
Interviews process: The data collection was done with the participants and had a duration of one hour and a half in each section. Each participant was interviewed twice; therefore, the total of time interviewed ranged approximately from 2 to 3 hours. The interviews were audio-recorded with the previous permission of participants, using a tape recorder as the primary recording device. Another tape recorder was used as a secondary, backup device. If the participant did not consent to audio recording, the researcher took notes during the interview, in order to record the participants responses as close to her own words as possible.

Participant were assured that they did not have to talk about anything they did not want to talk about, and that they could end the interview at any time. A pseudo name was used to refer to each participant to ensure confidentiality. In-depth interviews were used to explore and describe the experiences and perceptions related to the phenomenon of intimate partner violence among Puerto Rican women over age 60. This approach was selected for its naturalistic and a flexible structure that gives the participant the opportunity to express their feelings and thoughts (Seidman, 2006). The in-depth interview, itself, is a qualitative research technique that involves a series of intensive individual interviews with a small number of participants to explore their prospects on a particular life experience (Boyce & Neale, 2006). Using in-depth interviews is best suited for this study since the cultural beliefs of Latino families may influence women’s willingness to expose their experiences of IPV in groups, or in surveys. Puerto Rican women may have kept secret and silent about their IPV but may be willing to share their experiences in an atmosphere of privacy and security (Goldberg, et al., 2007; Gonzalez-Guarda, et al., 2013).
The model that was used to conduct the interviews was the one originally proposed by Dolbeare and Schuman (1982) adopted by Seidman, (2006). First, the women were thanked for agreeing to participate in the study; then, the purpose of this research was explained. Second, consent form sign was obtained (Appendix B). Any questions that occurred were answered before any intervention. Third, the participant demographic characteristics were obtained at the beginning of the first interview (Appendix C). All interviews took place in a private room in the women’s center. Before starting with the interview, women were asked how they wished for the man involved in the IPV relationship to be referred as, (e.g. partner, boyfriend or husband). This is important to maintain confidentiality, as well as to allow the participant to feel comfortable when the IPV perpetrator was addressed. In the initial interview, open-ended questions were used to encourage participant expression and experience. The most important factor was for the participant to reflect, relate and tell in detail their lived experience related to IPV with a minimum of interruptions. The topics of the first interview included: past life, her experiences, family, and community, as well as topics associated with IPV such as, her relationship with the abusive partner, experiences of abuse, types of abuse, perceived impact of IPV (physical, psychological and financial), and the ability to seek and receive health care. Also, participants were encouraged to share any previous disclosure of abuse to the friends, family, or healthcare team.

The second interview was conducted one week later to provide participants the opportunity to reflect on their experiences of IPV and the meaning of this experience in their lives. One week between interviews gave participants time to reflect on the previous interview, but not so long as to lose the connection between the interviews. In the second
interview, the investigator returned to participant with a summary and preliminary codes and categories derived from the first interview, for validation of the findings. Then each participant was asked to share the meaning of IPV experience in their life. At the end of each interview, the participant received a monetary stipend of $10 to cover transportation costs, for a total of $20 for both interviews. Even if the participant prematurely terminated participation, they still received $10 to cover transportation costs. If the women prematurely terminated the first interview, she may not be included in the study, or interview a second time; however, none of the participants abandoned interview.

The transcripts do not contain personal identifying information. Instead a study code was used to identify the interview data. The name of the participants only appeared on the informed consent, which is in a locked file cabinet separate from the interview data at the researcher's locked office. A master key including the participant name, and the study code is in a locked file separate from the consent form and data. Transcripts and the recorded audiotapes are labeled with the study code only and are also kept in a locked file cabinet at the researcher's office but separate from consent forms and master key. A pseudonym was used to refer to each participant during the interviews to ensure confidentiality. The audiotapes will be destroyed 3 years after the close of the research. The study codes were used to label data, no personal identifiable information was associated with data. Any computer hosting such data files has a password protection to prevent access by unauthorized users and is accessed only by the researcher. BOX, which is a protected drive, is used to store all electronic data. The BOX file is only accessible to the researcher and the advisor and will be de-identified. The BOX files are accessed only from secure password protected computers. At the conclusion of this study, the
researchers will publish their findings. Information was presented in summary format and the participant will not be identified in any publications or presentations.

**Data analysis**

To analyze the data gained through interview transcripts, Colizzi’s (1978) approach to data analysis was used to understand the experiences of older women exposed to IPV. The following steps from Colaizzi’s (1978) were followed: 1. Transcribed and read the descriptions of participants, 2. Selected excerpts of significant statements, 3. Formulated the meaning of statements, 4. Organized the categories into themes according to an understood meaning, 5. Integrated the findings to create an exhaustive description of the phenomenon, 6. Described the fundamental structure and meaning of the phenomenon as told by the participants, and 7. Validated the findings. Additionally, Van Manen’s (1990) thematic structure of four foundations served as a guide, to supplement Colaizzi’s step 6, to guide the reflection and interpretation of the phenomenon. To understand the meaning of women’s experiences with IPV, Van Manen’s thematic structure (1990) was implemented. Van Manen (1990) introduced a helpful guide for reflection on qualitative data, which are a) spatiality, b) corporeality, c) temporality, and d) relationality. These four existential themes allow us to ask about any experience because they usually pervade the world of all persons.

Spatiality, or lived space, is a category for discovering the ways people experiment issues related to daily living (Van Manen, 1990). Through spatiality, aspects related to the environment (home, places, body) are associated with the lived experience. Corporeality, or lived body, calls to the physical or body presence that can outwardly reveal something about the experience. Temporality, or lived time, refers to
subjective time as opposed to objective time (time kept through a clock). A person’s relationship with time was mediated by their age, their memories of past, present situation and hopes or expectations for the future. Finally, relationality, or lived other, refers to the lived relationship we establish with others in a particular moment in time. These four existential themes allowed the exploration of participants lived experiences of IPV through reflections of the themes and their experience of violence as it pertains to space, body, time and relationships.

The data analysis process began with word-for-word transcription of the participant narratives. Next, the transcripts were read and reread, and recordings were listened to identify key statements that reflect participant’s experiences with the phenomenon (step 1). Attention was paid to any feelings, thoughts or ideas that helped to describe the phenomenon. Using NVivo software to organize the data, significant statements that relate participants’ experiences were extracted from the transcripts (step 2), and compiled into categories, maintaining links to the participant statements that support the category. The researcher then searched for meaning in the data, to understand what was going on in order to fully describe the phenomenon (step 3). After the creation of categories and consideration of meaning from the first two interviews, the data analysis process was reviewed by the advisor and expert peer mentor, in order to reach a common consensus and verify that the process was sound and the meanings true to the participant reported experiences. When an agreement was met, the researcher continued in a similar fashion with data analysis. If a disagreement occurred, a discussion followed and the researcher proceeded as per the recommendations from the advisor and mentor, rechecking again after two additional interviews.
Once consensus was reached about the meaning of participant statements, the investigator proceeded to group statements into the categories that reflected similar meanings (step 4). The categories reflecting similar themes were incorporated together to form a prominent construction of the theme. The categories were included in a thematic map, which was verified by the researcher, mentor, and advisor. An exhaustive description was developed through the synthesis of the grouped themes and those associated with the meanings formulated by the researcher (step 5). The validation of the exhaustive description was review by the mentor and advisor. A reduction of the findings in which redundant descriptions were removed from the overall structure was conducted (step 6). The Van Manen’s four foundations assisted the researcher to best convey the meaning of the IPV experience among older women. The completion of the rigorous exhaustive analysis to find the essence of the IPV experience in older women was of extreme importance. Finally, the study findings were validated and discussed with a subgroup of participants (step 7). Any alterations that arose were made according to the participant’s feedback to ensure that the meaning was transferred to the main structure of the phenomenon. Following this member check of themes and meaning, the researcher integrated additional information provided by the subgroup of participants into the final description of the phenomenon (Shosha, 2012).

**Trustworthiness**

Trustworthiness in qualitative studies is established when the experiences of the study participants are accurately represented (Streubert & Carpenter, 2011). The operational techniques of Guba and Lincoln (1981) were used to support the trustworthiness of this qualitative research: credibility, transferability, dependability, and
confirmability. The credibility is related with activities that improve the probability that credible findings will be generated (Lincoln & Guba, 1985). The following activities may be conducted to ensure credibility: prolonged engagement at the site, peer debriefing, triangulation, member checks, negative case analysis, and external audit (Lincoln and Guba, 1985; Creswell, 2013). Creswell (2017) recommends that qualitative researchers choose at least two of these activities in any study. In this study prolonged engagement, member checks, and peer debriefing were used. Prolonged engagement was obtained through the in-depth interviews of 1 -2 hours as well as the two-interview format. This allowed sufficient time for participants to relate their stories and to reflect on the meaning of their experiences.

After transcribing data, the investigator returned to the participant for member checks. This activity allowed the validation of the findings by presenting the preliminary results of the analysis to the participants and confirming that this early analysis reflected their experiences. This step is congruent with the phenomenological data analysis method used in the proposed study (Colaizzi’s, 1978) as analysis begun as soon as the data was obtained.

Peer debriefing provided an external check of the data analysis process (Lincoln & Guba, 1985). In this activity, the researcher discusses with expert peers the ideas and interpretations in development of codes and themes. The opinion of peers can help the researcher to recognize their own biases and preferences. In addition, the researcher may receive advice on important methodological steps in the design (Lincoln and Guba, 1985). For this study, the researcher had debriefing meetings with an academic advisor
and a peer mentor to check how the research process was being conducted, the accuracy of the overall themes and cluster in a thematic map.

The transferability demonstrates the probability that the research findings have meaning to other in similar situation (Streubert & Carpenter, 2011). In this study, transferability was obtained through thick description of the women’s experiences. In this way, readers can make reasoned judgment about whether the study is transferable to their setting (Guba and Lincoln, 1982).

The dependability term has an emergent design so that changes are built in with conscious intent to prevents an exact replication of the study (Guba and Lincoln, 1982). Dependability was demonstrated with the description of the design and the implementation of the research. For example, some strategies were reviewed in the interview transcriptions to obtain significant statements, tapes were reviewed to insure the interview techniques consistency; furthermore, these activities are also consistent with the steps proposed for phenomenological data analysis (Colaizzi’s, 1978).

The confirmability is a neutral criterion for measuring the trustworthiness. In confirmability, it is important to provide enough information for other researchers who read the study to reach similar conclusions (Streubert & Carpenter, 2011). To achieve the confirmability, the researcher used the same strategies explained in dependability.

**Limitations**

The limitations of this study not only incorporate personal boundaries of the participants, but also lack of knowledge of IPV in this population as well as environmental factors. In this study, it was expected to interview ten participants; however, due to the events and effects caused by Hurricane Maria in 2017, the number of
participants were limited to six. Prior to this natural phenomenon, various centers were visited in order to recruit participants. It was stipulated that between five to ten participants, that met the inclusion criteria, attended these centers requesting assistance. However, because of the hurricane, these centers were forced to limit their operating hours, as a result of their loss of electrical power; they did not provide services until January 2018. When visited in February, they specified that the women who visited them were under the age of 60; consequently, because their age did not meet the criteria of this study, they were unable to participate. Therefore, other centers were contacted and a total of six participants were recruited. Despite the size of the sample, saturation was obtained.

Another limitation was the lack of previous studies that incorporated older women in Puerto Rico; this made difficult the contrast of data and the results obtained from this study. In addition, cultural limitations such as maintaining silence and not sharing relationship problems caused the reports of abuse less likely to occur. Also, the patriarchal culture in Puerto Rico makes older women stay in abusive relationship for longer periods of time without seeking the help of health personnel or centers that aid victims of IPV. Additionally, in the search for centers, one of them expressed that they did not allow interviews to be conducted because of their policies, that they could not to sign or make written statements or letters to the Institutional Review Board; therefore, their center was excluded from the study.

On the other hand, some women may have declined to participate in this study because they felt unable to discuss the experience of the traumatic event or were concerned about confidentiality. To avoid this, the researcher implemented a strict protocol designed to provide complete privacy and confidentiality. Furthermore, women
were reassured that they could withdraw from the study at any time without any sanctions or consequences if they felt unable to continue. Each participant’s experience is unique, and although there are common themes in their stories, it would be wrong to think that any presentation of findings completely represents each individual’s specific experience. Furthermore, it is not feasible to interview all women who fit the study criteria, and therefore it is possible that women who were not interviewed might have had different experiences than those who were (Groger, Mayberry, & Straker, 1999).

**Risk for participants**

The University of Massachusetts Amherst Human Research Protection Office (HRPO) was petitioned to approve this research study. Written informed consent was obtained from each participant (Appendix, B). Participants were informed of their right to stop the interview at any time they felt they could not continue. Although this study had minimal risks, the emotional aspect of talking about their experiences of IPV may upset participants. Every participant was provided with a debriefing form for participation in a research study that included a comprehensive and accurate list of clinical resources (Appendix, F). In addition, a crisis plan with the purpose of reducing the effects that could produce an emotional crisis would be provided in the event that any participant referred to an emotional problem or presented any of the following symptoms: crying, fear, irritability, tremors, despair, or any other manifestation of emotional crisis during the deep interview, however this was not necessary (Appendix, G).
Summary

The purpose of this study was to explore and describe the experiences and perceptions related to the phenomenon of intimate partner violence among Puerto Rican women over age 60. To that end, a qualitative research method, specifically, a phenomenology approach was used. The phenomenological method was best suited for describing the meaning of the lived experience of IPV. This research will add to nursing knowledge about the experiences of older women and inform health care that is patient-centered, and to policy development that will prevent IPV among older Puerto Rican women.
CHAPTER 4

FINDINGS

Demographic data

The purpose of the study was to explore and describe the experiences and perceptions related to the phenomenon of intimate partner violence (IPV) among Puerto Rican women 60 years of age or older. A total of six women participated in this research study (Table 3). The participants ranged in age from 62 to 73 years. Of the six participants, two were married, two were divorced and two were separated. Four of the participants graduated from high school, one participant had a bachelor’s degree, and one had only reached the seventh grade. None of the participants were employed. The income level of half of the participants was adequate while the other half of the participants verbalized that it was “totally inappropriate”. Half of the participants had their own house, the other half did not. All of them participants had children. All of the participants were medically insured. All participants had physiological health conditions, four of the participants suffered great emotional trauma and had psychological illnesses. All participants took prescription medications to treat their health conditions. The majority of the participants' partners were older than they were, the ages of their partners fluctuated between 66 and 88 years of age. Detailed demographic information may be found in (Appendix, D).
Table 3: Demographic data

<table>
<thead>
<tr>
<th>Participants</th>
<th>Age</th>
<th>Marital status</th>
<th>Children</th>
<th>Physiological Health conditions</th>
<th>Emotional health condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Morena”</td>
<td>62</td>
<td>Separated</td>
<td>3</td>
<td>Glaucoma</td>
<td>Major depression</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Osteoporosis</td>
<td>Bipolarity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Rheumatic arthritis</td>
<td></td>
</tr>
<tr>
<td>“Carmen”</td>
<td>66</td>
<td>Divorced</td>
<td>3</td>
<td>Hyperthyroidism</td>
<td>Anxiety</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Arthritis</td>
<td></td>
</tr>
<tr>
<td>“Violeta”</td>
<td>73</td>
<td>Divorced</td>
<td>3</td>
<td>Glaucoma</td>
<td>Not reported in demographics data</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Hyperthyroidism</td>
<td>Breast cancer</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Lucy”</td>
<td>66</td>
<td>Married</td>
<td>2</td>
<td>Hypertension</td>
<td>Anxiety</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>“Glory”</td>
<td>72</td>
<td>Married</td>
<td>4</td>
<td>Thyroid</td>
<td>Sleep problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Parkinson</td>
<td>Depression</td>
</tr>
<tr>
<td>“Debora”</td>
<td>73</td>
<td>Separated</td>
<td>1</td>
<td>Hypertension</td>
<td>Not reported in demographics data</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
This chapter provides firsthand accounts of the participants' stories. The interviews took place between August and December, 2018 and March and February 2019.

Five themes emerged from the interviews. To serve as a guide for the findings, I will use the two aims of this research study to organize the findings. See figure 1 and 2.

The two aims were:

1. To explore the experiences of IPV in a sample of Puerto Rican women over 60 years of age.

2. To consider the effects of IPV on women’s health.

Figure 1: Emergent themes, themes and subthemes related to aim 1
Aim 1: Experience of IPV

The first aim focused on the participants' experiences with IPV. The emergent themes related to this aim are adverse experiences in childhood and the impact of IPV. See figure 1 that show the emerging themes and theme clusters related to this aim.

Adverse experience in childhood

The first emerging theme is adverse childhood experience, this is important as it guides us through the childhood of the participants and how they describe traumatic events in their childhood.

Childhood experience

Childhood experiences included participants' memories, perceptions, and family relationships. As previously stated, half of the participants did not have an upbringing in which their parents were present, the other half did. Three of the participants expressed negative feelings when remembering their childhood.

Morena: “I do not like to talk much about my childhood, because it was not pleasant. My parents had me and from the time I had the use of reason, they lived a short time with me”.

Carmen: “So, we were a very nice family, but my dad was very strict, and he liked to hit us”.

Childhood trauma

The childhood trauma focuses on memories that remain throughout their lives; the participants expressed their feelings through the verbalization of the events. Traumatic childhood memories persist in the minds of some of the participants to this day. Two of them express feelings of anger or fear when relating their experiences.
**Morena:** “My mom still remembers anecdotes and talks about times she was drunk and that infuriates me, she makes me relive all the things that hurt me. I always asked myself why she brought those men home if she knew she had a daughter”.

**Carmen:** “Yes, we feared him, because when he would let us go out, for example, sometimes he would let us go to the movies it was in the same town. He would tell us you have until ten o’clock to get back here, but late, he would hit us and not let us go out anymore. He would hit us, without saying a word”.

**Witnessing IPV during childhood**

To be included in this emerging theme, the participants had to relate whether they witnessed IVP in childhood or adolescence in the community, school, or other settings. Three of the participants witnessed intimate partner violence carried out by close family members.

**Carmen:** “Yes, I witnessed an act of violence. Well I had an uncle that lived in front of my house, oh he would beat up his wife. Really, really difficult. The situation affected me, because it was a really intense violence. I would hide because I didn’t want to see that”.

**Glory:** “In my house. My dad grabbed a machete for my mother once. I had never seen him be aggressive towards my mom before or after that one time”.

“I had two sisters that got divorced because they were being abused. There was one that had a beating waiting for her every Friday. Well my sister stayed there”.

In summary, some of the participants experienced adverse events in childhood.
These events left traumatic experiences verbalized by the participants. Furthermore, they witnessed intimate partner violence within their family nucleus.

Influences of IPV

The second emerging theme is the influences of IPV on the women’s lives, this included the participants' experience of violence with their partners. Five themes emerged from this. The psychological theme has three subtopics: verbal, emotional abuse, and infidelity.

Relation with her partner

This theme focuses on the relationship of the participants with their partners and their experiences with IPV. Five of the participants had problems with their partners right from the beginning of their relationship. These problems persisted after the participants reached 60 years of age.

Before 60 years

**Violeta:** “That first year was full of battles too, even though I knew that he was aggressive because I was his neighbor, but we didn’t have a friendship with him. He used to abuse the partners that he had, when I fell in love with him, I didn’t see that’.

**Morena:** “He then would drink, he went out on the weekends and come back home at 3 or 4 in the morning. I held on to my kids, and I always said: “Jehovah I can’t leave this house, because I can’t go back to my mother’s house, and I have a house and work as a housewife”, so I decided to stay in that house”.

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After 60 years

**Violeta:** “I hope to continue like this, you know. Even though I know that I won’t get back with him. I won’t live through that suffering with him once more. I won’t go back”.

**Debora:** “He didn’t mistreat me for the longest time, because the mistreatment has only been happening as of late”.

**Physical Abuse**

The use of physical abuse in this theme is defined as: the use of physical force exerted by a partner or manipulation of an object with intent to harm such as punches, kicks, bites among others. Five of the participants experienced physical abuse by their partner before the age of 60. Only two of the participants reported that they still experienced physical abuse after the age of 60.

Before 60 years

**Glory:** “Like, after 5 months he hit me for the first time. In my face, it surprised me. I was 19 years old. I’ve had claustrophobia since then. I felt like the ceiling and floor were squishing me. I couldn’t even breathe, I had to go outside to be able to breathe because I couldn’t believe it… why he hit me”.

**Morena:** “I left the groceries and I went out alone to look for him at the business (bar), when I got there I told me: “what are you doing here?” and he brought out his fist and hit me in the face, I did nothing”.

After 60 years

**Carmen:** “Then, he was sleeping in another room and he appears with a knife and tells me: “I am going to kill you”. I braced myself and faced him”.
**Debora:** “That’s when, he got angry, he got up, I went to the kitchen and he was behind me and suddenly he takes his fists and hits me first in the face, because when he hit me I fell back on the sofa and when he went to hit me for the second time, I hit him in his foot and I placed my foot on his chest and pushed him back, he fell back on another chair”.

**Psychological abuse**

This theme includes verbal abuse, fear tactics, despective nicknames, humiliation, and infidelity by their partner. Three subtopics are included: verbal abuse, emotional abuse, and infidelity.

**Verbal abuse**

Verbal abuse in this subtopic includes insults, profanity, and yelling by their partners. Five of participants experienced verbal abuse by their partner before the age of 60. All participants indicated that verbal abuse did take place after the age 60.

**Before 60 years**

**Violeta:** “Bad words, offensive words, and really violent behavior.”

**Carmen:** “He insulted me, and I still did nothing”.

**After 60 years**

**Lucy:** “He has not changed, I would say that he has increased, yes he has become more verbally violent.”

**Glory:** “My husband still screams at me”.

**Emotional abuse**

The emotional abuse in this subtopic is defined as: the use of words with the intent to provoke negative emotions and feelings such as but not limited to:
embarrassment, fear, sadness or despair. Five of the participants experienced emotional abuse before 60 years of age. All participants experienced emotional abuse after 60 of age.

**Before 60 years**

**Morena:** “When he saw me, he told me: “girl look how fat you are (before I was very skinny), stop that mouth or you are going to get sick. You look like a manatee”.

**Carmen:** “During the holidays, well, we would go out and mingle, but I had to umm look out for him. That he may not like my behavior, you know, he would restrict me”.

**After 60 years**

**Lucy:** Yes, one feels humiliated, it’s hard, it’s not easy. It gives you grievances, sadness, I feel humiliated, I feel that I don’t have a partner, because I don’t have one, that I sacrificed my best years there, allowing such humiliation”.

**Glory:** “I’m going to tell you that he gets mad and I cry because of that, because he gets angry. Oh my God, you don’t let me live by calling me! Help me on this, and that makes me feel bad because I want the things that are given to me to be given with love. That they give it to me, or making a face like the one he made, that even worse.”

**Infidelity**

In this subtopic, infidelity is defined as: an extramarital affair, sexual in nature.

Four of participants experienced infidelity before 60 years of age.
Before 60 years

**Carmen:** Then when my child was born well, he started to behave well, but then he started behaving badly again because he was a womanizer. So, then the women would look for him at home, would call him through the phone, he used the boy and it was to meet with a woman. And then the boy would tell me.

**Lucy:** “We have been nearly 26 years without having sexual relations because he had a son outside our marriage”.

**Sexual abuse**

In this subtopic sexual abuse is defined as: all sexual contact without the person’s consent. Only two participants experienced sexual abuse before age 60.

Before 60 years

**Violeta:** “He was in my house and he arrived, and he wanted to have sex with me, but I didn’t want to. And then he took me to the bedroom and closed the door to the bedroom but then he went to the bathroom and the moment he went to the bathroom, I opened the door, ran, looked for the keys that were in the table, I quickly opened the gates and I went to my own house, running”.

**Morena:** “After the aggressions I had to be with him again, it was something that I could not mentally be there with him, I couldn’t be with him. It was something horrible. The physician examined me and told me: “you lubricate”, but I couldn’t, he thought I was fine. I felt raped”.

**Economic abuse**

Economic abuse in this subtopic is defined as: a lack of monetary support from their partners with the intent to hinder their basic day to day activities. Four of the
participants experienced economic abuse before 60 years of age. Only two participants experienced economic abuse after the age of 60.

**Before 60 years**

**Violeta:** ‘The only thing he did when he got paid on Fridays was that he used to give me $20 dollars, in the 1980s. I practically worked for about one year, after I started dating him. I later stayed as a housewife and didn’t receive any type of payment, only the money that he gave me. There were times that I said to him: “Hey, where are my $20 dollars from Friday? Aren’t you going to give them to me?”, and he told me: “I’m not going to give them to you, since you didn’t do anything around here”.

**Glory:** “And then I started “reliving” not having a heater, or refrigerator, and I thought that I was leaving my house for a better life. A better life of everything and it wasn’t like that. I ate food unseasoned sometimes because there was no salt”.

**After 60 years**

**Carmen:** “This affects me economically, too much”. “There was a time that he controlled my money. Then later he wanted to control the money, but I told him no”.

**Lucy:** I went to the physician and I did not have enough to pay, I took from him, borrowed $10.00 to pay and he tells me: “ oh sorry what a problem”, like this amount of money, when I came back at night I paid him back his $10.00.

All of them experienced the IPV phenomenon, providing great context of what their relationship was like before the age of 60 and after the age of 60. Indubitably IPV
exposure continues after 60 years of age. The participants, sometimes with great strain, give testimony of the way in which they were verbally abused. They maintain that the verbal, emotional, and economic abuse was present even after the reached the age of 60.

Figure 2: Emergent themes, themes and subthemes related to aim 2
Aim 2: Effects of IPV

The second aim of the study is related to the effects of IPV on the participants. The emergent themes related to this aim are the implied effects of IPV in the participant state of mind, and creating structures and coping strategies to support IPV victims. See figure 2 that show the emerging themes and theme clusters related to this aim.

Implications of IPV

The third emerging theme is the implications of IPV related to the experiences that have impacted the way of life of the victim, beliefs related to IPV, and health of the participants. Three theme cluster emerge from this theme.

Feelings

This theme includes the participants' expression regarding the IPV experience and their sentiments. All participants were able to express their feelings and their thoughts with respect to their experiences with IPV.

Glory: “I felt like a small cockroach, an ant, and that’s how I’ve felt living beside him”.

Carmen: “When I saw him oh, I felt fear, I felt very displeased, it reminded me of everything I lived, a sort of movie came to mind, Oh no! I saw a sort of monster. I saw like, I see in him a sort of evil aura”. “Yes, that’s how I see him, when I see him, when I have to go to court, I know that I am going to see him.”.

Beliefs related to IPV

This topic focuses on participants' experiences related to the influences and beliefs present in the relationship. All participant verbalized that “machismo” has an influence in IPV and that the two are intertwined on a global scale.
Lucy: “The machismo had influence, because the man feels superior to the woman and I don’t consider them more superior I consider them equals”

Carmen: “There is a lot of “machismo” and influence in these experiences. My ex-partner was “machista”. The “machismo” does relate with violence. For example, I could not dress like I wanted to, I could not wear makeup like I wanted to, I couldn’t go where I wanted to.

Morena: “It would be the same, this is global. My sister in law married an Arab and she left him a long time ago. This is seen everywhere”.

Health problems

The participants expressed that they suffered health problems that had a direct association with the abusive nature of their relationship. All six participants blamed IPV for their mental and physical ailments.

Morena: “This relation affected the mental area, it also affected me physically, I have a phobia of relationships. I have become disgusted of men”.

Carmen: “For example, I had hyperthyroidism, but I was cured of it and when I had those problems again, it activated. I did not suffer from anxiety and now I suffer a lot from it.

Violeta: “In these last years is that my blood pressure is rising, but it is because of the situation that I’m living in”.

During discourse with the participants they were able to share their feelings and experiences. From these testimonies, important points came to light, such as the fear that haunted them and all of the negative memories associated with the IPV experience. They also indicated that one of the key beliefs that enables IPV is machismo. This concept is of
great influence in relationships and can be present in any country. Furthermore, they express physical and psychological health problems associated with IPV.

Structure support to face IPV

The fourth emerging theme is the need to create a structure to support IPV victims and to face the phenomenon. This supports system is defined as: any group, person or institution that helps an IPV victim to overcome and deal with their trauma.

Four theme cluster emerge from this theme.

Religion

This theme focuses on the participants religious beliefs and how those influence IPV. Four of the participants express that religious beliefs provide them with support in an IPV situation.

Carmen: “And they opened my eyes and then well when I spoke with the man from church, he told me: “the decision is yours, God doesn’t like what he is doing but the decision is yours”. And from there on out I well begun to open my eyes. Church was a support for me”.

Violeta: “Well I think that religion is protective, but I don’t think religion to be the motive behind the fights in marriages”.

Debora: “‘Well look in my case it hasn’t been that way, because one of the persons that has told me that I can’t get back with my husband is my pastor, he has told me that my life is in danger. And not only mine, my son’s as well. He has been looking out for us and he asks me: “How are you feeling? Are you better now?”.”
Seek help

Seeking help refers to when a victim of IPV contacts health professionals in order to escape an abusive situation. All of the participants expressed that the services received helped them deal with their IPV trauma.

**Morena:** “. I did not know about places like this for me this is new. It has been very good. Here I have been treated very well and seeing that there are other people like me makes me feel better.

**Carmen:** “The care here has been very good. They have helped me a lot. Very good, very good, very good. I had, another social worker that they now changed because she left, very good. She helped me a lot. And the one I have now is very good as well. The psychologist is very good as well.

**Violeta:** “Here in the group they have helped me quite a lot mentally, emotionally, the advice. Helping me regain strength and try to lose my fear for him because there is no need for me to be scared. I have more strength, well because of the support I’ve been given here as well”.

Disclose

This theme includes any and all people that the participants selected to share their experience of IPV. All of the participants disclosed on some level their abuse to other people such as family, friends, or health professionals.

**Violeta:** “Only that the neighbors knew and my sons. They know about the fights and that, but what they said to me was to leave him. They told me: “Leave that man you can’t keep being with him, he is going to kill you!” but I wouldn’t leave him”.

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Debora: “Well my neighbors, church, pastor and the physician all knew about the last event”.

Glory: “Yes, my mother knew, my dad, my brothers, children’s and friend”.

Escape of Violence

In this topic, participants verbalized how they escaped violence. Five of the participants thought that they could get out of their abusive relationship.

Carmen: “Then, well he locked himself in the room, I called my son and my son said: “Mom don’t call the police, I’ll be right over”. And he came home and told me: “Let’s go to court, let’s ask for a protective order”

Violeta: “Sometimes I go two months to my daughter’s house in New York or two months to my sister’s house in Long Island, now I’m leaving to Texas, the next month to where my son lives, I’m going to be two months over there and that’s how I live by”.

Participants went into great detail about how support structures had a positive influence in their lives. The support system found in religion, family, friends and health professionals is a key step in the road to recovery of victims suffering from IPV.

Coping strategies

The fifth emerging theme is the construction of coping strategies. These strategies must include sober perception, critical thinking, and a deep reflection on what strategies we should use to identify an abused woman. Thus, one theme emerges.

Reflection on meaning

This theme includes the thought process of participants after living in a IPV environment. In this step we incorporate the recommendations given to us by the
participants in order to create a more helpful model.

Morena: “One was not born together with that person and even tough one is married for life, there are limits, why should one be with a man that mistreats you”.

Carmen: “They should emphasize the support groups because us since we are older, we suppress each other. Because, we are older that is for the young girls that fight with their boyfriends, that fight with their husbands and many of us well we keep quiet and we reach this age with all that because we kept quiet and there should be like some support group that helps us talk and not hold what we have held for so much time, so much time”.

Violeta: “That they leave and not look back because if you do stay after that initial hit, you will stay and receive more beatings. Because after the first hit one like starts to get scared and later on one will stay there because of the fear of leaving him. You have to leave that person’s side”.

Lucy: “Well you have to be aware of all of the signals notice be they verbal and physical abuse, to look for help because not everyone is the same, not everyone can protect themselves”.

Glory: “I believe that no woman is going to stay like that. My daughter is 53 years old and she remembers, you know, about those things. And she remembers that mom and dad have their imperfections. She comes to me and says that I didn’t leave, that I stayed there withstanding everything from her dad”.

Debora: “I would not want anyone to go through this experience. For no woman to go through this experience because it’s not easy and when one is older it’s not
the same. For them to not remain silent. They should communicate it to a family member, a physician, if they go to a church, their pastor, to their counselor. They should talk about it. When these things happened, one should not remain quiet, one has to communicate, because when one remains with those things bottled up it hurts them more, than the hit, or the words they say. If you say it or get it out and you get rid of it, it’s like a weight that you get rid of”.

After experiencing the IPV phenomenon, the participants talked through how they coped with it during their lives and gave some recommendations to share with other IPV victims such as: to disclose the abuse with a close friend or family member, to search for ways to access health professionals, and, most crucially, to not wait any longer to escape an abusive relationship.
CHAPTER 5
DISCUSSIONS OF FINDINGS

This chapter contains the discussion and interpretation of the findings as reported in Chapter 4. Colaizzi’s (1978) method was used as a guide for the analysis of the lived experiences of participants. The focus of this discussion will be to examine the meaning of the experiences of women over 60 with IPV. The findings will be interpreted using the theoretical assumptions of Heidegger's and Van Manen, which will facilitate the reader's understanding of the experiences lived by the participants.

The discussion will be organized according to the findings and emerging themes that came to light from participants' lived experiences. Themes that emerged from the analysis are: (a) Adverse experiences in childhood, (b) Influences of IPV, (c) Implications of IPV, (d) Structure support to face IPV, and (e) Coping strategies

Adverse experiences in childhood

Three participants verbalized how they underwent adverse experiences in childhood, and how these memories remain ever so present in their consciousness. Three participants spent their childhood with their grandparents or relatives. These adverse experiences during childhood lead the life-long negative feelings about their childhood. Take for example, how two of the participant’s memories of childhood evoked feelings of distrust and violence. The participant, Morena, expressed that her childhood was not at all pleasant, and Carmen said that her father was extremely strict and that he beat her. The traumatic events that these participants had to endure, resulted in continued feelings of fear or anger towards their parents. Three of the participants witnessed an act of intimate partner violence perpetrated by a close member of the family. Three participants
expressed that witnessing the act of violence was exceedingly difficult, and that it affected them heavily given the intensity of the violence. Three participants witnessed both physical and emotional abuse in childhood. Now as an adult the memory of those events is still present, re-experiencing the fear, discomfort, and disgust.

It is important to highlight that intimate partner violence and child abuse is a global public health problem (Carlson, Namy, Pala, Wainberg, Michau, Nakuti, Knight, Allen, Ikenberg, Naker, & Devries, 2020). On the other hand, child abuse began to get social attention at the early 1960s, but it is possible to find references from past years (Child Welfare Information Gateway, 2017). Listening to the participant’s detailed accounts of adverse experiences during their childhood paints us a picture of how bad the problem of child abuse was during this time period.

To great dismay, in Puerto Rico, the problem continues today. The number of reported cases of child abuse in 2018 was 12,870 and in 2019 3,862 (Department of Family, Government of Puerto Rico, 2019). The types of abuse reported are neglect, physical, psychological, emotional, and sexual abuse (Child Welfare Information Gateway, 2017). Although cases of abuse continue to be reported, research to implement, eradicate, and mitigate the effects of violence in Puerto Rico is minimal (Pérez, Sánchez, Martínez, Colón, Morales-Boscio, 2016).

Different types of abuse are produced by sociocultural factors and problems such as family discord, intimate partner violence, divorce, alcoholism, among others (Family Department, Government of Puerto Rico, 2014). Five participants lived under a sociocultural background such that discord, divorce, and alcoholism were all part of their day-to-day lives.
Childhood experiences of violence include the testimony of violence initiated by the father, and corporal punishment (Afifi, Mota, Sareen, MacMillan, 2017). This directly correlates to Carmen's lived experiences; she clearly verbalized the physical abuse she suffered at the hands of her father. In the literature we can find evidence of how these adverse experiences that women are subjected to begin in childhood (McMahon, et al., 2015). Women who have experienced some form of childhood trauma are at an increased risk of experiencing intimate partner violence later in life (Fulu, et al., 2017). Two participants were able to verbalize the connection between enduring traumatic experiences during their childhood, and IPV in their adult lives. For example, Carmen shared that she was afraid of her dad because he used to hit her, and he was a very strict person.

The experience of abuse is usually carried to a woman’s next stage with her new family and intimate relationship (Huecker & Smock 2020). Three participants summarized that the abusive and traumatic events of childhood continue hurt them even today, that childhood is a distant memory that recalls only pain. The vicious cycle of violence in these women’s lives seemed to continue. After they married, a new chapter of abuse began; intimate partner violence. It is key to note, that these participants continued to experience intimate partner violence deep into their adult lives, even after the age of 60.

Heise (1998) proposed the ecological model that contains the systematic vision that serves to describe how violence occurs through the interaction of a set of factors. The government of Puerto Rico is currently working on the application of a prevention model to reduce, or eliminate, child abuse. In the plan for the prevention of child abuse in Puerto
Rico, the ecological model was used (Department of Family, 2014). This model has four risk factors, each factor has an allocated level: society, community, family, and individual (Heise, 1998; Department of Family, 2014). Risk factors at the individual level are related to the presence of personality disorders, mental health problems, use of controlled substances, history of violent behavior, and having been a victim of abuse (Heise, 1998).

Risk factors at the family level are associated with family structure and resources such as: family size and composition, couple conflicts, dysfunctional parenting patterns, having been victims of mistreatment when as younger, and intimate partner violence (Heise, 1998). In the community level, risks are associated with poverty, unemployment, and a high incidence of crime (Heise, 1998). In the social and cultural environment, risks are related to economic and gender inequality, racism, values instilled in the upbringing, acceptance of violence in family relationships, public policies that do not consider changes in society, discipline, and welfare (Heise, 1998; Department of Family, 2014).

The usefulness of the model lies in the information and the structure that it provides to root out and prevent child abuse. The ecological model fits with some of the risk factors experienced by the participants in this study. At the individual level, exposure to a diverse range of maltreatment, and/or abuse during childhood is representative to this factor of the model. At the family level, parental use of controlled substances, such as alcohol, by parents, IPV within the family and other functional parenting patterns, are representative of the model factor in this sample. At the community level, poverty was a risk factor for four of the participants. Finally, at the social and cultural level, two expressed that cultural values such as machismo affected how their parents behaved and, in turn, how they were treated. Seeing brutal violence encroach in family relationships
was a normal occurrence to them, it was a phenomenon present in almost every aspect of their immediate environment.

To address these issues, the Department of Family of Puerto Rico issued guidelines for the years 2014-2021, which contain protective factors. These are: the healthy social and emotional development of minors, knowledge about responsible parenting and parenting in general, and education on child development for caregivers, among others. Also included are protective factors for couples that have no gender violence or substance abuse. (Department of Family, 2014).

Summary

It is remarkable to see just the amount of psychological and physical abuse these participants have survived. However, as much as they tried to cope and endure the trauma in order to survive, it has taken a definitive toll on their lives. The emotional and physical abuse was exacerbated by the extreme poverty that seemed to suffocate any chance of an “out”’. The normalization of abuse in childhood made adulthood dating violence seem like nothing out of the ordinary, thus continuing a pattern of abuse throughout their lives.

The ecological model provides the tools for the early identification of child abuse. The problem that affects the individual, family, community, and culture. It is imperative to identify if a child is experiencing abuse, or other adverse situation.

The goal must be to work on the reduction, and eventual elimination, of risk factors, using tools that contribute to the protection of children and the prevention of violence. It should also include education, preparation of programs for the prevention of abuse, adequate parenting skills, communication skills and anger management, among others.
Influences of IPV

All six participants shared their IPV experiences, many situations abuse were relived and remembered. Three participants were exposed to IPV in their first or second relationship. The feelings that arose during the narration of these experiences were sadness, anger, frustration, humiliation, disappointment, deception, among others. It is not a hyperbole to say that the souls of the participants have been deeply wounded for decades, that the abuse was deliberate. Five of the participants have had to deal with abuse their whole lives. The following section will include a discussion of the relationship between couples, and how the different types of abuse occurred. Although difficult for some, these experiences were all shared willingly by the participants during their interviews.

Relation with her partner

These relationships were toxic and any feelings that could be interpreted as love, or care, were clouded by the dark shadow of violence. Three participants experienced IPV as soon as their first or second romantic relationship. Four expressed being exposed to different types of abuse by their second relationship. The insidious abuse ranged from outright physical abuse, to manipulation. These included: physical and verbal fights, intrusions into the women’s daily routines (e.g. arriving uninvited at dawn), excessive alcohol use by the partner, unwarranted aggression, and attempts to control behavior (e.g. being forced to stay at home). These abuses were experienced throughout the women’s lives.

IPV occurs within interpersonal relationships where there is discord, or conflict between the couple (CDC, 2016). All of the participants of this study were not able to
articulate why IPV happens. Some studies have found that the dominant role of the husband in a relationship increases the risk of IPV (Adebowale, 2018).

Antisocial personality disorders, including aggressive behaviors, has been studied as risk factors for IPV (National Center for Injury Prevention and Control, Division of Violence Prevention, 2019). All the participants in this study said that their partner was aggressive and mistreated them in various ways. Five participants expressed that during the first year of the relationship there were many battles. Moreover, alcohol use, a predictor of IPV, is related to the effects of aggression (Aggarwal, Sinha, Kataria, Kumar, 2016). Five participants shared their experiences of violence related to alcohol use by their partners.

Physical abuse

One in five women in the US, have experienced physical violence from their partner at least once in their lifetime (National Center for Injury Prevention and Control, Division of Violence Prevention, 2019). In one study, the authors found that the duration of IPV was between 25 to 37 years (Davies, et al., 2015). The participants in this study experienced intimate partner between 30 and 47 years. All the participants suffered punches, kicks, bites, and threats with a knife, sometimes having to fend off the aggressor to save their own lives. Even after the age of 60, they continued to experience physical violence, disturbing the peace and tranquility associated with this later stage of life. Indeed, elderly IPV is more common that what is expected. A research study found that older women are in fact exposed to physical abuse by their partners (Sanz-Barbero, et al., 2019).
Physical abuse was experienced by five participants before the age of 60. Five participants verbalized that the physical abuse began as soon as they started their relationship. Two participants explained how the violence continued even after they were 60 years old. Past research supports the finding of this study, that IPV occurs in women over 55 as well as in younger women (Fraga, et al., 2017).

Psychological abuse

The overall theme of psychological abuse includes three subtopics, verbal abuse, emotional abuse, and infidelity. Five participants were exposed to verbal abuse before the age of 60, while all experienced this type of abuse after the age of 60. All participants expressed that their partner said offensive or curse words to them. This was usually during a physical altercation. Verbal abuse experienced by the participants includes offensive words, name calling, increased verbal violence, and yelling from their partner. The participants remember these moments with sadness and dread. Many cannot help but cry and disappointment arises when talking about these experiences. The memories of the verbal abuse remain intact. Exposure to acts of abuse leads to negative effects on psychological well-being (Costa & Botelheiro, 2020).

Years after the fact, deep wounds remain in the psyche of the participants from the verbal abuse. Indeed, verbal abuse is prevalent in this population (Canell, Weitlauf, Garcia, Andresen, Margolis, Manini, 2015; Bhatia & Soletti, 2019). All the participants said that their partner had become more verbally violent after the women reached 60 years of age. Studies support that verbal abuse in older women is high (Sood, et al., 2016). All participants expressed that their husbands constantly yell. According to the
finding of this study, as well as those mentioned above, it can be said that verbal abuse is prevalent among older women.

Five participants experienced emotional abuse before the age of 60, after 60 they all experienced emotional abuse. The participants expressed feelings of humiliation, limitation, and sadness. In one case, the body image of the participant was attacked, as her partner compared her to a manatee. Traumatic events that resulted in crying, pain, anger, and helplessness are vividly remembered by many. Bhatia & Soletti (2019) summarized various schemes of emotional abuse which included rejection, humiliation, fear, and isolation. The Centers of Disease Control (CDC) define emotional abuse as including name calling, humiliation, and control to monitor or threaten the partner (CDC, 2020). Participants verbalized that their partner restricted their activity and controlled their lives. All participants expressed feelings of grief, sadness, and humiliation.

Participants in this study experienced various forms of emotional abuse that are consistent with what is available in the literature.

Infidelity is another issue that is related to psychological abuse. Four participants revealed infidelity by them of their partners before the age of 60, but no infidelity after the age of 60. The discovery of infidelity impacts the emotional aspect of the relationship causing a whirlwind of feelings. The initial phase after discovering infidelity may include feelings of shock, anger, or confusion (Carlson & Dermer, 2016). Infidelity is related to a relational violation and devaluation of the person; in other words the couple's relationship has not been valued, or the norms agreed upon by one of the members have not been followed (Utley, 2017). Carmen said that her partner used their child to meet women. Carmen expressed feelings of anger and betrayal. Upon discovering infidelity feelings of
harm and pain arise (Utley, 2017). Lucy did not agree to sexual relations with her partner after he had a son out of wedlock. This participant imposed the rules of sexual intercourse, which were accepted by her partner. Four participants remained in a relationship with their partners, even after they acknowledged that they had been unfaithful. Although they remained in the relationship, the participants expressed feelings of sadness, anger, deception, and humiliation.

**Sexual abuse**

Two participants reported sexual abuse before age 60. After the age of 60, the participants did not experience sexual abuse. Sexual violence is often accompanied by emotional and physical abuse (Bagwell-Gray, 2018). All participants in this study experienced emotional and physical abuse by their partner. Physical or sexual assaults can be associated with severe violence, disability, and death (Du Mont, Woldeyohannes, Macdonald, Kosa, Turner, 2017). Later in this chapter, health problems caused by experiencing intimate partner violence are explored.

Sexual abuse can be related to dominant cultures such as machismo or gender inequalities (Du Mont, et.al., 2017). The two participants verbalized that after being physically assaulted they were also subject to sexual assault by their partner. The risk of sexual assault in Puerto Rican couples may be related to the culture of machismo, as this is a cultural value. When recounting these events the participants experienced anger, discrimination, frustration, and fear.

**Economic abuse**

Four of the participants talked about economic abuse before the age of 60,
however, after the age of 60, only two participants verbalized having financial problems. In addition to physical abuse and other types of abuse, there is economic abuse, in which the perpetrator maintains power in the relationship by controlling financial resources (Sanders, 2015). Women who are financially dependent on their partners are at greater risk of experiencing abuse, and less likely to leave the relationship (Sanders, 2015). Five participants verbalized having to endure a wide range of abuse for more than 20 years.

To maintain control, the abuser controls financial resources, interferes with his partner's employment, manages regular access to money, and denies access to financial information, among other tactics (Adams, & Beeble, 2019). Four participants expressed that their partners worked and controlled the financial resources. Four participants verbalized that financial resources were often restricted, monitored, or completely out of their access. Four participants talked of how the partner denied things they needed, such as; routine visits to the physician, food, heat, and refrigeration, among others. They shared how their partners got angry and belligerent if they asked for money to meet basic needs. Four of the participants had feelings of anger and frustration over this lack of financial support.

**Cycle of Violence**

Participants have experienced various types of abuse throughout their lives. There are several theories that explain the phenomenon of abuse in couples. Walker (1979) developed the theory of the Cycle of Violence to explain the patterns of behavior in an abusive relationship. The three-phases of the theory are; tension-building, serious battering, and the honeymoon (Walker, 1979). During the first phase the aggressor expresses hostility without violence, and the woman tries to calm him down and deflect
his anger. During the second phase, aggression and a serious incidents of violence occur.

During the third, and final stage, the aggressor tries to atone for what he has done (Walker, 1979). The cycle repeats over and over again during the relationship.

When applying it to this study, in the tension creation phase, we found that most of the participants verbalized having problems with their partner from the beginning of the relationship. These included fights, a drunken partner arriving at dawn, insults and curse words, arbitrary restrictions, nicknames, humiliations, yelling, among many others. In this phase, the participants remained silent and accepted whatever it was that their partner wanted, or said so that the act of violence would not escalate.

In the serious battering phase, participants suffered physical abuse, which included punches, kicks, bites, verbal, emotional, and sexual abuse. The victim expressed negative feelings towards this aggression, humiliation, surprise, courage, fear, shame, sadness, among other feeling were expressed. One of the predictors of violence was the use of alcohol by the abuser. Most of the participants expressed that their partners used alcohol before they became aggressive. According to most of the participants, they did not know the reason or motive for the aggression. They also reported that physical abuse was sometimes the result of some insignificant situation. During this phase most women only sought surface level help. A few phone calls to the police, neighbors, or friends. This can be related to the fear they felt towards the aggressor during that moment. Participants also expressed that sometimes there were more people watching the aggression, but did nothing to help.

In the honeymoon phase, participants expressed that their partner said they would change, but they did not. Other participants after the aggression, had to engage in sexual
acts with their partner. All participants expressed that after the aggression everything continued, as if nothing had happened.

The violence experienced by the participants follows the Cycle of Violence theory, as it repeated, and over the years became more violent (Walker, 1979). In addition, there are some social components that are related to the occurrence of the cycle of violence, among these is insensitivity towards abused women, tolerance of violence and socializing children in traditional gender roles. (Walker, 1979). Also, patriarchy or the dominant role of men are part of this problem. (Walker, 1979). Inadequate protection from the police, courts and medical professionals are reasons why abused women remain with the aggressor (Walker, 1979).

Summary

The experience of intimate partner violence in most of the participants has been right from the beginning of the relationship. The types of abuse experienced by the participants were physical, psychological (including verbal, emotional, and infidelity), sexual, and economic. The voice of the participants narrating these past experiences lend a sort of visceral credence to the wide range of abuse they suffered. Physical and psychological abuse were the most common.

The theory of the Cycle of Violence helps to understand what is happening in an abusive interpersonal relationship. To eliminate this cycle of violence, it is important to work in educating women from an early age so that they can identify aggressive behaviors. Nurses can also provide the resources and tools necessary for the protection of women so that they can get out of this cycle of violence. Also, important, is to work to
reshape traditional gender roles, starting from family education in early childhood, promoting mutual respect and values that serve equally all family members.

Implications of IPV

The pain in the voice of the participants as they recounted their traumas speaks to the severity of what they survived. It was as if their hearts and minds were still entangled with every word and act of abuse that, at one point in their lives or another, was hurled at them. IPV has kept those wounds open. The participants have stored feelings deep in their hearts, those too will be discussed in this chapter. For these participants the culmination of all of their feelings and cultural beliefs faced the, seemingly, inescapable consequences of violence at the hands of their partners.

Feelings

All six participants expressed how they felt about their IPV experience. The suffering had marked them. It was expressed with the following words: humiliation, crying, courage, sad memories, horrible, painful, indignation, irritation, and sacrifice. The damage caused by these abusive experiences caused many of the participants to cry, as did remembering how helpless and angry they felt.

The stories that women exposed to IPV tell are rarely of positive emotions or feelings. Words that do associate with the IPV experience are fear, sadness, and anger (Tani, Peterson, Smorti, 2016). Emotions transform into anger when exposed to acts of violence (Baloushah, et al., 2019). The feelings of worthlessness, helplessness, hopelessness, unhappiness, and insecurity arise over time and shocking the quality of life of women exposed to IPV (Fraga, et al., 2017). This literature completely agrees with the reality of the participants in this research.
To guide participants' feelings, the thematic structure of Van Manen (1990) will be used. The structure contains four existential themes that are: spatiality, corporeality, temporality, and relationality. The experience related to the issue of spatiality focuses on the environment where the abuse arose. Related environments are the home, public places, the car, among others. A home is supposed to be the place where the individual feels the safest. This makes the wide range of abuse experienced by the participants even more frightening. The walls and the rooms of the house did not act as foundations to a safe space, rather they imprisoned the participants in a hellscape. The beds did not serve as a place of respite, they were the vessel of sadness that the participants used to remember their traumas. The kitchen, far from being a place of culinary creativity, was a room filled with potential weapons that the aggressor could use to end the victim’s life on a moment’s notice.

This macabre reimagining of common settings was not limited to the house. At the business (bar), or in the cockfighting establishments, houses of relatives or friends; it did not matter. The fury of the perpetrator seemed to be without limit. It was seen in its worst form, in front of anyone, and without any remorse. They were not exempt of abuse even while in the car. All these inanimate objects bear the memories of what once happened. They continue to be a reminder for the participants in which all they see is abuse.

On the theme of corporality, participants transform their body or report seeing their partner in an animate, or inanimate way that are not directly related to that person. When experiencing different types of abuse, painful feelings arise in the participants. One of the participants verbalized feeling like a small cockroach or ant living with her partner.
all her life. The minimization a victim uses to describe themselves can prove to be devastating as they will feel that they are unable to leave their partner. Another participant stated that when she saw her partner after separating, she saw him as a monster or a bad aura. The memory that remains causes feelings of fear or contempt to arise that are all associated with the events of abuse. The way that the mind transforms the human being into something else, is directly related in these cases to the experience of abuse, lacerations of the body and soul, impotence, humiliation. All feelings that the participants expressed.

Time seems to meld together for these participants who experienced IPV. This includes periods of Christmas, the early mornings, days, and nights of experiencing humiliating, painful, and violent events. For the women in this study, rather than a joyous occasion, Christmas was a time of solitude and restriction. Two expressed loneliness at Christmas, as their partners celebrated alone. In addition to spending the holiday alone, when their partners arrived at the house, they were drunk and aggressive. Another participant expressed that at Christmas she was restricted by her partner, because he did not like her attitude. If she did not act the way that he wanted when he got home, violence began. The mornings were endless for these women who did not know under what conditions they would see their partner. At night, sleep was interrupted by the threats with knives, screaming, or other types of abuse. Uncertainty reigned over the eternal days, not knowing what your partner would do next. Fond memories were replaced with negative feelings, all associated with the abusive experiences.

The relationship theme includes the interpersonal relationship and the problems associated with different types of abuse. Five participants expressed from the beginning
that the relationship was problematic. The role of the participants in the relationship was to be at home, to take care of the children, to be a housewife. In the economic aspect, most of the participants depended totally on their partner. The power struggle, the abuser over the victim, had marked the relationships. The mistreatment destroyed any hope of a normal relationship. Multiple exposures to IPV made the relationships a painful, humiliating, and irritating endeavor in which suffering was evident. The helplessness of knowing that their partners were unfaithful disrupted peace and trust in the relationship. After many years, a great number of the participants ended the relationships thus, at last, breaking a relationship founded upon suffering.

These four themes come together and help interpret the complex experiences of the participants. When combining them we can see the phenomenon universally, thus we include the essential components that are related to their experiences. To understand how and why these themes are being united, we can visualize figure 3. These topics include negative feelings evoked from decades long abuse. In this structure, it can also be clearly seen how the cycle of violence is maintained throughout the lives of these women.
Beliefs related to IPV

All of the participants in this research agreed that the cultural phenomenon known as “machismo” influenced their experiences of IPV. Participants defined machismo as when men consider themselves superior to women. They also believe that it is a global problem. Machismo is a risk factor that is associated with IPV (Mancera, Dorgo, Provencio- Vasquez, 2017).

The gender roles under machismo are associated with negative emotional and cognitive factors. These negative factors may have negative implications in the physical
and emotional health of women. The traditional aspects of machismo are dominance, sexism, emotional restriction, and hostility (Nuñez, et al., 2016).

In Puerto Rico, the traditional family structure is patriarchal and contains elements of machismo. In a patriarchy, the father is the highest authority, while the woman must be submissive. Patriarchy is related to a social structure that fosters differences between men and women. Many of the parenting styles of Latinos contain components of machismo, where the father plays an authoritative, firm, and strict role (Mogro-Wilson, et al. 2016). Vulnerable women, including those who experience IPV, are more dependent on others. In the Puerto Rican culture of male dominance, women are pushed into a subordinate position. These factors increase the risk of IPV and are related to patriarchy (Sikweyiyi, et al., 2020).

Dobash & Dobash (1979) proposes the three basic principles that have been identified in patriarchal theory. The first is wife assault, in this the man dominates the woman and has social control. Second is assault is committed by the man who thinks that patriarchy is his right. Third is the use of violence to maintain the dominant role as acceptable. Patriarchal theory focuses on the IPV in society and the quest to explain why men mistreat women. (Dobash & Dobash, 1979).

To explain how the three principles of patriarchal theory work, will be associating the experiences of the participants with each one. Some of the situations experienced by the participants are related to the first principle. These include the stories of the women that verbalized how the control and administration of the financial resources was done only by their partner. They also expressed that her partner’s controlled over them remained even when outside of the house. In the second principle, two of the participants
experienced sexual assault by their partner after being physically abused. This situation made them feel raped. Finally, in the third principle, five of the participants remained with the perpetrator for many years thus tolerating the behavior of the dominant role after receiving all kinds of abuse. The three principles of patriarchal theory are consistent with this culture and with the experience of machismo.

Participants openly expressed their beliefs that machismo is one of the causes of abuse. When speaking of machismo, the feelings that arose were of anger, humiliation, and impotence. The control and the dominant role on the part of their partner is clearly perceived in how they expressed the abuse done to them. One of the essential needs is to achieve gender equality throughout the world, as it is one of the IPV occurrence factors. Women who receive such exposure to IPV for long years are afraid and are often humiliated by their partners, this can be observed in the situations expressed by the participants.

Health problems

The health problems that participants express as directly related to IPV include mental and physiological health issues. According to participants, the physiological health problems include thyroid problems, hypertension, and insomnia. Two have scars from many years of physical abuse. Six of the participants expressed mental health problems such as: anxiety, claustrophobia, compulsion, relationship phobia, nervousness, and bad mood swings. Feelings of fear, sadness, low self-esteem are also associated with mental illness (Moulding, Franzway, Wendt, Zufferey & Chung, 2020). Acts of physical violence can lead to long lasting physical pain and other problems.
Physical abuse is associated with poor self-perceived physical health (Winter, et al., 2020). Other problems related to IPV, and its effects on physical health condition, are cardiovascular disease, chronic pain, and sleep disturbances, (El-Serag & Thurston, 2020). Five of the participants expressed that they suffered from these conditions. The numerous years of IPV exposure led participants to seek treatment from health care professionals. Given the is relationship between IPV and health risks, it is important that health care providers pay attention to the telltale signs of IPV in the populations that they treat.

Summary

The negative feelings expressed by the participants are associated with IPV. Van Manen’s model (1990) provides a structure in which to understand the experiences of the participants, in space, body, time, and relationships. This model helps us understand the damage, injuries, and psychological wounds that these women carry both in body and spirit.

Machismo associated with patriarchal cultures puts women at risk of IPV. Traditional gender roles, in Puerto Rico, fail to recognize women’s rights, empowering only men. Therefore, it is important to change the perception of traditional gender roles through education with a goal to create healthy environments for couples that promote equality, respect, and understanding.

According to participants, physical and mental health problems arise from exposure to IPV over many years. The damage and consequences of these experiences cause problems in the health of participants. Health professionals should be made aware
of the association between IPV and health, as they are in positions to screen women for IPV.

Structure support to face IPV

Four of the participants verbalized that religion is an IPV protective factor. Additionally, all participants sought help from health care professionals. Women disclose IPV to family, friends, or health professionals. After 60 years of age, four participants decided to abandon their former abusive lives with the support of their church, physician, friends, and family.

Religion

Four of the participants verbalized positive aspects related to religion. Indeed, when the women talked to people in the church, they found solutions to help with IPV. They also reported feeling support, comfort, and concern from people in the church. Women prefer to seek help from their religious leaders, rather than going to IPV centers or government agencies (Akangbe, 2020). However, the religious leaders may lack the necessary education and adequate training to help IPV victims. Sometimes, these spiritual leaders recommend praying and going to church to solve IPV problems (Gezinki, Gonzalez-Pons, & Rogers, 2019). Other researchers found women were supported by their religious leaders and found effective support to leave the IPV relationship, stay safe, prepare an escape plan, or otherwise manage the abuse (Sabri, Nnawulezi, Njie, Messing, Ward-Lasher, Alvarez, et al., 2018). Studies found that the church and the community were positive factors in leaving the abusive relationship (Godoy-Ruiz, Toner, Mason, Vidal, & McKenzie 2014). Four of the participants expressed that religion was a support system for them.
Seek Help

All six participants were seeking help after years of IPV. When seeking help, they expressed that although they hesitated seeking help from strangers at the IPV support centers, they felt good once they were there. In addition, the participants verbalized that the treatment they received by health professionals in the centers was very good, better preparing them to face the problem of IPV.

Severe abuse causes women to seek medical attention, mental health services, or legal assistance (Domenech del Rio & García del Valle, 2019). Obstacles to help-seeking included; presumptions that IPV is a private matter, lack of knowledge about the available assistance, and lack of access to legal services (Hu, Xue, Lin, Sun, Wu, & Wang, 2020). Women also may not seek help due to financial dependence on the abusive partner (Murphy, et al, 2020). The participants in this study shared that they stayed with their partners for many years because they had to keep their family together, they had nowhere to go, they feared their partner would hurt them, and they were financially dependent on the abuser. They also expressed that they were not aware of services to help victims of IPV. Three factors, (a) patriarchal culture, (b) the notion that keeping marital problems private, and (c) fear of sharing information with health care providers were the barriers to seeking help most frequently discussed by the Puerto Rican women interviewed.

However, women who did seek help reported feeling comfortable talking with their counselor, whom they felt were empathetic, respectful, trustworthy, and highly ethical (Sapkota, Baird, Saito, Rijal, Pokharel, & Anderson, 2020). When health providers have good rapport, eye contact, and listening skills, victims are more likely to
share their experiences of abuse (Correa, Cain, Bertenthal, & López, 2020). Although it was after the age of 60 that all of the participants in this study decided to seek help, they found health professionals to be caring, and helped them improve, received support, and feel better mentally and emotionally.

Disclosure

All six participants only disclosed that they suffered IPV with people they trusted, such as: neighbors, church members, pastors, physician, friends, children, parents, police, and mother in-laws. Women who verbalized severe physical violence shared their experiences of abuse with someone within their social environment (Domenech del Rio, et.al., 2019).

Most women with IPV exposure seek support through informal sources such as family and friends (Domenech del Rio, et al., 2019). Informal social support systems, such as family and friends, may be helpful on some occasions, but in others may not help in the process of leaving the abuser. In many cases informal supports provide counseling, encouragement, and help (Barrios, Khaw, Bermea, & Hardesty, 2020). On many occasions, reported by the participants, family and friends witnessed the IPV and just watched, without doing anything.

Escape of Violence

Because of the help provided by their family, friends, church, police, health professionals, and/or legal support, a vast majority of the participants had escaped from the violence. Realizing that they had the support of others and acknowledging that they were experiencing IPV, the participants decided to leave their relationship.
Latin women commence to seek the help they need to escape violence once it becomes too severe (O’Toole, Schiffman & Sullivan, 2020). Cultural factors in Latina women make the action of seeking help and escaping violence less likely compared to other racial groups (Álvarez & Fedock, 2018). Women that were injured, that violence affected their well-being, or that experienced fear or control by their partners, were more likely to tell someone about their experience of violence and access help services to get out of the relationship (Murphy, et al., 2020). In this research, five participants had escaped violence, and were currently adjusting to their new lifestyle. The support and supervision of help centers is an important factor in helping the victim stay safe. The others who have also provided help, be it family or friends, are of key importance in the continuous support and assistance that the participants need. The services provided by the women’s centers, such as housing, psychological counseling, and government aid must continue to be provided to ensure the safety and health of the participants.

Summary

Religion served as a support structure in the decision to seek help and leave their partner. Although researches have associated religion with remaining in abusive relationships, for the participants in the current study, this was not the case.

Moreover, even if they had spent many years enduring IPV, four women eventually sought help and terminated their relationship. In addition, sharing their experiences with health professionals in IPV centers was a positive factor in their health and management of IPV, and provided a trusted resource. Sharing information with people in their social circle helped them receive needed support and was helpful to them
in resolving problems. After reporting their experiences and receiving help, they were able to end the abusive relationship.

Coping strategies

After reflection on their IPV experiences, the women expressed offered their thoughts, feelings, and suggestions. From the deep pain and scarring suffered during their lives, words arose, allowing them to express a common message that relationships should never be based on violence. A life where abuse and control prevailed, led participants to be reactive to the abuse, and hypervigilant for their safety. Their lives were forever shaped by the many years living with IPV.

Reflection on meaning

Participants expressed there should be limits in a relationship, and that abusive behavior, and mistreatment should not be accepted. Additionally, they verbalized that they experienced many types of abuse over many years. Indeed, when women remain in abusive relationships, fear of the abuser develops, resulting in women remaining the relationship, allowing for the cycle of violence to continue. Furthermore, it was mentioned by the participants, that they had to be always vigilant for signs that indicated the abuse was escalating, such as: screaming, insults, or hitting. They also expressed that women should not stay in the relationship for the sake of children. Besides, indicated that over the years the children claimed that they had stayed with the abusive partner for so long and had witnessed events that emotionally hurt them. Lastly, they insisted that it is important for women to share their experiences of abuse and not remain silent. Revealing the abuse helps relieve the strain and ease the emotional pain that they carry.
As the participants explained, it is not easy for older women to understand how vital it is to get out of the cycle of violence.

Understand and interpret the phenomenon of IPV among older Puerto Rican women. Heidegger's concepts and structure were used to reflect on the meaning of IPV among the women. Among the principles of Heidegger's philosophy, the principle of existence or "being in the world" is acknowledged as being related to the inseparability of the person from the world (Heidegger, 1927/2011). The concept of being, and being in the world, are associated with the world temporality, spatiality, and the care structure.

The concept presented by Heidegger is “Dasein”, which focuses on the notion of a "living being", and is related to the activity of "being there" and "being in the world". Individuals are not separate from their contexts. The contexts influence their decisions and give meaning to their lived experiences (Heidegger, 1962). Dasein is one concept, that, along with beliefs, norms, and values, is consider to influence the lived experience of an individual (Heidegger, 1927/2011). Dasein provides a structure of understanding to guide human experience. This structure includes fore-having (all humans arrive at a situation with knowledge of their own world), fore-sight (the sociocultural background), and fore-conception (sociocultural knowledge), giving a basis for a preview of what could be found through research. These three elements represent areas for interpretation (Heidegger, 1927/2011; Benner, 1994). In this research, interpretations, and the meaning of lived experiences, emerged through Heidegger's structure of understanding.

The first element to discuss is fore-having, this is related to the family structure of the participants, encompassing the fact that some of them were raised with members who were not biological parents. A variety of the childhood experiences that were verbalized,
caused discomfort and negative feelings. Additionally, exposure to emotional and physical abuse was expressed by some of the participants. Witnessing intimate partner violence during childhood caused a negatively affected them, still remembering them as uncomfortable moments filled with unwanted violence. Moreover, the use of alcohol intake abuse by parents, poverty, and family dysfunctional patterns were risk factors in the participants. The participants’ childhoods include individual factors, such as exposure to abuse; social factors such as witnessing IPV, poverty and alcohol abuse by parents; and cultural factors like the Puerto Rican upbringing in childhood.

The upbringing of a child in Puerto Rico, and teaching them respect, has negative and positive aspects. Communication, comprehension, and the ability to listen do diverse opinions reflect the positive aspects of this. However, children are taught that respect also means that men are the ones who make decisions, and no one could say otherwise. Therefore, children could not make decisions and had to respect and obey their father or caretaker. Consequently, if the child did not abide by their parents orders and rules, they would receive what is colloquially known as *pelas,* which means they would get hit with objects such as rulers, sticks, or even simply with their hands, as expressed was by the participants. Furthermore, when adults are speaking, children are told to remain silent. Even though there have been changes throughout the generations, it is still common to hear Puerto Rican children told that adult conversations are not be disrupted by children. This may cause children to assume a submissive role when facing a figure of authority, for example, the father. When control is excessive, children to have lasting effects during adulthood. The exposure to trauma or adverse experiences during childhood, led the
participants to be vulnerable as adults to IPV, and to continue in the relationship for years, even past the age of 60.

The second element is fore-sight, which focuses on cultural factors involved in being in the world. In Puerto Rico, the culture is patriarchal, which leads to gender inequality. Currently, a vast majority of Puerto Rican men hold positions of power and receive higher salaries when compared to women (Office of the Ombudsman for Women, 2019). Patriarchy and machismo are associated with IPV in Puerto Rico (Office of the Ombudsman for Women, 2020). All the participants talked about how they had started their relationships rather quickly, without knowing the partner well. Consequently, the relationships included disharmony and conflicts.

Other cultural factors that influenced the lived experiences of the women include the belief that relationship problems are supposed to be solved in the confines of the home, and no one else in allowed to comment on the matter. This belief puts women at risk for IPV because they fear sharing their experiences: *el qué dirán las demás personas* (what will other people think and say).

The last element used in interpretation is fore-conception. In Puerto Rico, there are different religions. That being said, religion plays the role of an institution that expresses their views on political and social aspects; furthermore, they form part of the cultural norms, and they influence the decisions of their followers. The behavior and decisions of their followers are dictated by the religion they belong to (Cruz-Santos, 2015). One of the factors that appeared to help the participants leave their abusive relationship was their religion. The leaders of some religious groups promoted an atmosphere of trust and honesty, giving the woman the needed support to leave the
relationship. Indeed, religion seems to bring a sense of support and comfort during
difficult times.

Moreover, seeking help in centers that specialize in IPV gives the participants the
opportunity to gradually heal by revealing their abuse and expressing their feelings. In
these centers they also offered financial aid, medical services, and housing. The majority
of the participants expressed that they had begun to experience a feeling of rebirth and
wellbeing with the help of counseling services, visits to the psychologist, appropriate
treatment, support, and quality care. Others mentioned that they still need time to heal,
and for the fear to subside in order to begin a life of tranquility and peace.

The participants did not remain completely silent when the abuse occurred, they
shared with family, church members, friends, parents, and police, among others. It should
be noted that, although certain people knew about this situation, they were not true
support groups. For years, the participants continued to be exposed to all types of abuse.
In many instances, the people that the victims turned to for help did not know how to
provide it. For this reason, it is necessary to educate the victims on where to look for
help. Help should be sought at a center specialized in intimate partner violence, a place
that can provide the necessary help for victims of IPV.

Two women had to attend the emergency department due to the extreme severity
of the violence. When asked how they felt being treated, they responded that the staff was
kind and caring. The staff included physician and nurses. On one instance, the abuser
became aggressive and the police had to transport him to prison. The very next day the
participant retracted the abuse accusation and so the cycle of violence continued. Asked
about how she felt about this situation, the participant said a great shame washed over her
and that it prevented her from seeking help again. It is important that women exposed to IPV receive specialized help at centers qualified to aid victims of IPV. Physician, nurses, and other health professionals are educated to be alert to signs of abuse, such as beatings, psychological torment, or mental illness that may be related to abuse.

**Conclusion**

This research focused on the experiences of women 60 years or older with histories of IPV. Their experiences with adversity, violence, and abuse often began in childhood, and reverberated throughout their entire lives. Traumatic stories were told that involved childhood physical abuse, emotional abuse, and the exposure to IPV at the within the family. The abuse continued throughout the women’s lives, lasting for decades. Participants were still being traumatized even after 60 years of age. The abuse was physical, psychological (verbal and emotional), sexual, and economic. Among the feelings that arose from the adverse experiences were humiliation, suffering, sadness, and anger. The participants associated their physiological and mental conditions to IPV exposure. In addition, patriarchal cultural factors and machismo were seen as causes of IPV. Puerto Rican culture has rooted patriarchal and “machista” influences that increase the risk of IPV in women.

Factors such as religion, friends, and health professionals, factors that support women, were also key for them to escape an abusive relationship. The participants' reflections included their own experiences as well as suggestions for other women and nurses. After reflecting on past experiences participants provided advise that women should not allow abuse in a relationship, at the first sign of any abuse, women should seek help. They also would tell others to disclose the abuse to family members, and to
health care professionals, who can help break the cycle of violence so that they would not be trapped in it for years.

**Implications for nursing practice**

This study reveals important elements for nursing professionals, pertinent information that will help to better understand the impact of intimate partner violence. The terrible impact of IPV was fully displayed in the stories told from the very same people that lived through it over decades. Participants expressed that the careless violence withered their lives causing physiological and mental illnesses. Fear of their partner and financial dependence were some key factors in explaining why they did not seek help.

Nursing professionals offer a wide range of health services that the elderly population benefits from. Infirmary workers has the most contact with older women, as they provide direct care. Patient assessment is an important instrument to identify cases of IPV, as it includes social factors, physiological and mental illnesses, among other important data. Nursing professionals should know where the centers that specialize in and treat IPV are located. These centers provide the crucial tools that educate the victims in how to deal with and escape the cycle of violence.

This screening should occur in women of all ages because IPV has no age limitations. It is important to mention that during this interview, the nurse must be alert to possible signs that may be associated with IPV. Early identification of IPV is important to prevent long-term damage to physical, mental, and emotional health. For this reason, nursing must improve detection and interventions strategies that identify and attend IPV cases effectively. Empathy and active listening are important factors that help the victim
feel comfortable enough to disclose if she is suffering from abuse. Once abuse is identified, it is important to have the knowledge and tools necessary to help victims get out of the cycle of violence. A vetted list of resources has to be ready in case you need to contact specialized IPV centers and make the appropriate referrals, whether for shelters or any other service requested by the victim.

In Puerto Rico, law number 54 was enacted to protect the victims of abuse. It facilitates the prevention and intervention with intimate partner violence, repudiates cases of intimate partner violence and promotes healthy relationships between couples, including values of peace, dignity, and respect (LexJuris, 2019). Although this law exists, cases of intimate partner violence continue to rise, threatening women of all creeds and colors. Although many women do decide to file a protection order against their abusive partner, some of these women are still relentlessly pursued by their abuser, often resulting in their death. Ignorance of the existence of professional health care services and the burden of financial needs, make women withdraw protection orders, and return to the cycle of violence. Poor management of cases and the failure of the state to provide these women with a safety net make them more vulnerable. The laws are already in place, the state must simply be more diligent in the handling of these delicate cases. The abuser must not be allowed to act with impunity.

These women need to able to find an escape out of the cycle of violence and make life changing decisions, health care centers can provide that crucial guidance. These centers help them in finding a safe home, financial aid, and medical services. A very important factor in women’s decisions to end the violence is the age of their children. This greatly influenced the participants’ acceptance of outside help. It is important to
recognize and eradicate this dangerous paradigm through education, explaining how keeping the family together in violent relationships does not help, it only harms children as well as women. This toxic environment erodes the possibility of a healthy future for everyone involved, leading to problems both physical and emotional.

The participants vehemently insist that no one should be a victim of IPV. They also comment that now, with the knowledge that they have acquired, at the first sign of abuse they would leave the relationship, that they would never wait as long as they did to leave the cycle of abuse. In addition, they verbalized that women should not remain in a relationship plagued by IPV to keep the family together. The participants said that the children witnessed many instances of abuse, this caused great stress and sadness to the participants. Keeping silent is not an option. The abuse must be revealed so that the cycle is, once and for all, broken.

In response to the outcry of diverse sectors, government agencies are funding efforts whose aim is to help IPV victims. These different funding projects facilitate the development of health care tools that provide the victims with financial aid, a place to live and health services at very low or no cost. Violence prevention strategies such as healthy parenting approaches, anger management, and emotion management are vital in dealing with IPV. Early identification of IPV, along with referrals to the appropriate health care specialists help the victim deal with the trauma of violence; it leads them towards the path of intervention and puts an end to the cycle of violence.

Implications for future research

This research explored the experience of IPV in women over the age of 60. The findings of this study provide evidence to support the idea that this elderly population of
women experiences different types of abuse than other groups in Puerto Rican society. It is important to highlight the importance of continuing to study how this population fares against diverse social and health issues. Government funding of health centers provides additional support to women dealing with IPV. These women are in dire need of help and the early identification of these cases should be a priority for health professionals. The government’s agencies must redirect efforts to further support the work that is being done to curb this enduring and unjust health problem.

Some of the questions that may be addressed in future studies are:

Do cultural values serve as predictors of IPV in older women?

What strategies should the nursing professionals use to identify and intervene in cases of IPV where the women are over 60?

Do early prevention strategies in children help to decrease IPV in adulthood?

How do older women that were victims of IPV for decades adjust when free of violence?

These questions emerge from the need to better know, understand, and help the victims of IPV. Qualitative research can offer great opportunities to study the phenomenon of abuse. Case study and phenomenology are recommended since they can be adapted to fit our cultural environment. This would provide a deeper analysis of the topic in addition to providing information for prevention, management, and intervention with this population. The use of theories, such as the cycle of violence, the ecological model, and the Van Manen structure should be used to guide future research.
Meaning of the experience of investigating

This research experience provided me with a vast amount of information on a subject that can be the difference between life and death for a sector of our population. It peeks the door open into an area of health care that was previously unknown. Having the privilege to hear the voices of the participants as they told me their experiences dealing with IPV gave me the opportunity to reflect on my own feelings. I felt a shrouding somberness learning, firsthand, that even as they grew old, they were subjected to abuse and torment. A stark contrast to the supposed golden years that they ought to live, a stage expected to be a calm and happy one. I also felt anger against the aggressor, specially when one of the participants burst into tears after telling me how she was mistreated.

This process was complex, and it provided me with an opportunity to learn and understand IPV experiences. It is not an exaggeration when I say that it has been one of the biggest challenges of my life. The experience took a toll on my personal life, forcing me to carry out introspection exercises on many occasions. The feelings of sadness and despair remained rattling inside of brain day in and day out. As I reflected on what the participants told me, I better understood the scope of my research. It was my duty as a health care professional to help them deal with their trauma and I took that mission personally. Later during the day, the task of transcribing, reading, rereading, and reevaluating transcripts would begin. From this work, the emerging themes and subtopics were arranged in a logical and coherent way.

At times, the research silhouetted itself as an impossibility. During those moments of doubt, I reminded myself who it was that would benefit from my work. Women who have spent their entire lives surviving abuse and torment, women who have never had a
voice and thus could never escape the wretched cycle of violence. I will remember this experience until my last day on earth. It is my goal to continue working alongside victims of intimate partner violence and to help them to search for solutions that benefit and help them to escape of the cycle of violence.
Invitation to participate in Research Study

Older Women’s experiences of Intimate Partner Violence:
A Phenomenological Study

Criteria for participation:
1. Participate voluntarily
2. Puerto Rican woman, 60 years of age or older who has experienced intimate partner violence with a man
3. Spanish-speaking

Participants will be expected to:
Participate in two Interviews. Each will last approximately 1 hour to 1½ hours, for a total time of approximately 2 to 3 hours. At the end of each interview, participants will receive $10 to cover transportation costs.

If you are interested in participating in this study, please contact the researcher
Lourdes Irene at:
➢ lourdes.irene@upr.edu
➢ 787-925-4999, 787-758-2525 ext. 2157 or 1093

Thanks!
Invitación para participar en un estudio de investigación
La Experiencia de las Mujeres Mayores con la Violencia de Pareja Íntima: un Estudio Fenomenológico

Los criterios de participación son los siguientes:
1. Participar voluntariamente
2. Ser una mujer puertorriqueña de 60 años o más que ha experimentado violencia de pareja
3. Su idioma principal debe ser el español

Se espera que los participantes:
Participen en dos entrevistas. Cada una durará aproximadamente de 1 hora a 1 hora y media, el tiempo total será de aproximadamente 2 a 3 horas. Al final de cada entrevista, los participantes recibirán $ 10 dólares para cubrir los costos de transporte.

Si está interesado en participar en este estudio, por favor póngase en contacto con la investigadora Lourdes Irene o por correo electrónico a:

➢ lourdes.Irene@upr.edu
➢ 787-925-4999, 787-758-2525 ext. 2157 0 1093.

¡Gracias!
APPENDIX B

CONSENT FORM FOR PARTICIPATION IN A RESEARCH STUDY
University of Massachusetts Amherst

Researcher(s): Karen Kalmakis, PhD- Professor, College of Nursing, UMASS-Amherst, and Lourdes Irene RN, MSN- doctoral student, College of Nursing, University of Massachusetts (UMASS), Amherst

Study Title: Older Women’s experiences of Intimate Partner Violence: A Phenomenological Study

1. WHAT IS THIS FORM?

This form is called a Consent Form. It will give you information about the study so you can make an informed decision about participation in this research.

This consent form will give you the information you will need to understand why this study is being done and why you are being invited to participate. It will also describe what you will need to do to participate and any known risks, inconveniences, or discomforts that you may have while participating. We encourage you to take some time to think this over and ask questions now and at any other time. If you decide to participate, you will be asked to sign this form and you will be given a copy for your records.

2. WHO IS ELIGIBLE TO PARTICIPATE?

To participate in this study, women must comply with the following inclusion criteria: 1) Puerto Rican women age 60 or older who have experienced intimate partner violence involving a man. 2) Spanish speaking and able to understand what will be expected of them as a participant, and be able to give informed consent. Exclusion criteria include: 1) Participants under 60 years of age 2) Women who are injured or ill at the moment of recruitment. 3) Women who are not able to provide consent because they are under the influence of a substance, or have a cognitive impairment, and 4) Women whose intimate partner violence relationship is with another woman.
3. WHAT IS THE PURPOSE OF THIS STUDY?
The purpose of this study is to explore the phenomenon of intimate partner violence among Puerto Rican women over age 60 through the experiences and perceptions of the women.

4. WHERE WILL THE STUDY TAKE PLACE AND HOW LONG WILL IT LAST?
The research will be conducted in the “Centro envejecer en Armonía” and in "Casa Pensamiento de Mujer del Centro”", Psychotraumatology Institute and Dr. Lorna Oyola general and preventive medical office. The collection of data will take place over a one-year period. Interviews will last for approximately 1 hour to 1 ½ hour. Each participant will be interviewed twice, therefor the total of time interviewed will be approximately 2 to 3 hours. The interviews will be recorded, with the permission of participants, using a tape recorder as the primary recording device. Another tape recorder will be used as a secondary, backup device. The interviews will be conducted in a private office in each of the centers.

5. WHAT WILL I BE ASKED TO DO?
If you agree to take part in this study, you will be asked the following 1) to answer a brief questionnaire and 2) to participate in two interviews. The topics of the first interview include past life experiences, family, and community relations, and topics associated with intimate partner violence such as, relationship with the abusive partner, experiences of abuse, types of abuse, perceived impact of intimate partner violence (physical, psychological and financial), and the ability to seek and receive health care. You may skip any question you feel uncomfortable answering.

6. WHAT ARE MY BENEFITS OF BEING IN THIS STUDY?
You may not directly benefit from this research; however, we hope that your participation in the study may have help benefits for others. Also, your voice in this process it is needed to explore how we can develop better resources and interventions for women exposed to intimate partner violence.
7. WHAT ARE my RISKS OF being in THIS STUDY?
Participants will be informed of their right to stop the interview at any time they feel they cannot continue. Although this study has minimal risks, the emotional aspect of talking about their experiences of intimate partner violence may upset participants. It is for this reason that information on mental health resources and emergency numbers will be given to all participants at the first interview. In addition, you will receive immediate assistance if needed.

8. HOW WILL MY PERSONAL INFORMATION BE PROTECTED?
To protect the confidentiality of your information in the records of the study, the following procedures shall be used:
The transcripts will contain no personal identifying information. Instead a study code will be used to identify the information you provide.
Your name will only appear on the informed consent, which will be kept in a locked file cabinet separate from the interview data at the researcher's locked office. Transcripts and the recorded audiotapes will be labeled with a code and will also be kept in a locked file cabinet at the researcher’s office but separate from consent forms. A pseudonym will be used to refer to you during the interview to ensure confidentiality. A master key that links your name and a study code will be kept in a secure separate file. The master key and the audiotapes will be destroyed 3 years after the close of the research. The participant codes will be used on all electronic data, this no containing identifiable information. Any computer hosting such files will have password protection to prevent access by unauthorized users and will be accessed only by the researcher. BOX, which is a protected drive, will be used to store all electronic data. The BOX file will be accessible to the researcher and the advisor only. At the conclusion of this study, the researchers may publish their findings. Information will be presented in summary format and you will not be identified in any publications or presentations.
9. WILL I RECEIVE ANY PAYMENT FOR TAKING PART IN THE STUDY?

At the end of each interview, the participant will receive a monetary stipend of $10 to cover transportation costs, for a total of $20 for both interviews. If the participant prematurely terminates participation, they will receive $10 to cover transportation costs. If the women prematurely terminate the first interview, she may not be included in the study, or interviewed a second time.

10. WHAT IF I HAVE QUESTIONS?

Take as long as you like before you make a decision. We will be happy to answer any question you have about this study. If you have further questions about this project, or if you have a research-related problem, you may contact the researcher(s):

Lourdes Irene
Phone: (787) 925-4999
Email: lirene@nursing.umass.edu or lourdes.irene@upr.edu

Karen Kalmakis
Phone: 1-413-577-4763
Email: kalmakis@nursing.umass.edu

If you have any questions concerning your rights as a research subject, you may contact the University of Massachusetts Amherst Human Research Protection Office (HRPO) at (413) 545-3428 or humansubjects@ora.umass.edu

11. CAN I STOP BEING IN THE STUDY?

Your participation is voluntary, and you do not have to be in this study if you do not want. If you agree to be in the study, but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to participate.

You may cancel this authorization at any time by sending a written notice to the investigators at the following address:
Lourdes Irene  
University of Puerto Rico  
Medical Sciences Campus  
School of Nursing  
PO Box 365067  
San Juan, Puerto Rico 00936  
or by email at lirene@nursing.umass.edu or lourdes.irene@upr.edu

Karen Kalmakis  
University of Massachusetts  
School of Nursing  
Skinner Hall 222  
651 North Pleasant Street  
Amherst, MA 01003-9277  
Or by email at kalmakis@nursing.umass.edu

12. WHAT IF I AM INJURED?
The University of Massachusetts does not have a program for compensating subjects for injury or complications related to human subject’s research, but the study personnel will assist you in getting treatment.

13. SUBJECT STATEMENT OF VOLUNTARY CONSENT
When signing this form, I am agreeing to voluntarily enter this study. I have had a chance to read this consent form, and it was explained to me in a language which I use and understand. I have had the opportunity to ask questions and have received satisfactory answers. I understand that I can withdraw at any time. A copy of this signed Informed Consent Form has been given to me.

_____ I agree that segments of the recordings made of my participation in this research may be used for conference presentations, as well as education and training of future researchers/practitioners.

_____ I agree to have my recordings archived for future research in the field of Intimate Partner Violence.
I do not agree to allow segments of recordings of my participation in this research to be used for conference presentations or education and training purposes.

I agree to audio recording

I disagree with audio recording

By signing below, I indicate that the participant has read and, to the best of my knowledge, understands the details contained in this document and has been given a copy.

Obtaining Consent
Formulario de Consentimiento para Participación en un Estudio de Investigación
Universidad de Massachusetts-Amherst

Investigador(es): Karen Kalmakis, PhD- Profesor, Escuela de Enfermería, Universidad de Massachusetts-Amherst y Lourdes Irene RN, MSN- estudiante doctoral, Escuela de Enfermería, Universidad de Massachusetts- Amherst (UMASS)

Título del Estudio: La experiencia de las mujeres mayores con la violencia de pareja íntima: un estudio fenomenológico

1. ¿QUE ES ESTE FORMULARIO?

Este documento se llama un formulario de consentimiento. Le proporcionará información sobre el estudio para que pueda tomar una decisión informada sobre la participación en esta investigación. Este formulario de consentimiento le dará la información que necesitará para entender por qué se está realizando este estudio y por qué se le está inviando a participar. También describirá lo que usted necesitará hacer para participar y cualquier riesgo conocido, molestias o incomodidades que usted pueda tener mientras participa. Le recomendamos que tome un tiempo para pensarlo y hacer preguntas ahora y en cualquier otro momento. Si usted decide participar, se le pedirá que firme este formulario y se le dará una copia para sus registros.

2. ¿QUIÉN ES ELEGIBLE PARA PARTICIPAR?

Para participar en este estudio, las mujeres deben cumplir con los siguientes criterios de inclusión: 1) ser mujer puertorriqueña de 60 años de edad o más que haya experimentado violencia de pareja que involucre a un hombre. 2) hablar español y ser capaz de entender lo que se espera de usted como participante, y ser capaz de dar su consentimiento informado. Los criterios de exclusión incluyen: 1) participantes menores de 60 años 2) mujeres que estén heridas o enfermas en el momento del reclutamiento 3) las mujeres que no pueden dar su consentimiento porque están bajo la influencia de una sustancia, o tienen un deterioro cognitivo y 4) las mujeres cuya relación de violencia de pareja íntima es con otra mujer.
3. ¿CUÁL ES EL PROPÓSITO DE ESTE ESTUDIO

El propósito de este estudio es explorar el fenómeno de la violencia de pareja en mujeres puertorriqueñas mayores de 60 años a través de las experiencias y percepciones de las mujeres.

4. ¿DÓNDE SE LLEVARÁ A CABO EL ESTUDIO Y CUÁNTO DURARÁ?

La investigación se llevará a cabo en el Centro envejecer en Armonía, en la Casa Pensamiento de Mujer del Centro, Instituto de Psicotraumatología y la oficina de la Dra. Lorna Oyola consultorio médico general y preventivo. La recopilación de datos tendrá lugar durante un período de un año. Las entrevistas durarán aproximadamente de 1 hora a 1 ½ hora. Cada participante será entrevistado dos veces, por lo tanto, el total de tiempo de ambas entrevistas será aproximadamente de 2 a 3 horas. Las entrevistas serán grabadas, con el permiso de los participantes, usando un registrador de cinta como dispositivo de grabación principal. Otro registrador de cinta se utilizará como un dispositivo secundario, para copia de seguridad. Las entrevistas se realizarán en una oficina privada en cada uno de los centros.

5. ¿QUÉ SE LE SOLICITARÁ HACER?

Si acepta participar en este estudio, se le pedirá lo siguiente: 1) contestar un breve cuestionario y 2) participar en dos entrevistas. Los temas de la primera entrevista incluyen experiencias de vidas pasadas, relaciones familiares y comunitarias y temas relacionados con la violencia de pareja íntima, como la relación con el compañero abusivo, las experiencias de abuso, los tipos de abuso, el impacto percibido de violencia de pareja íntima (físico, psicológico y financiero) y la capacidad de buscar y recibir atención médica. Puede omitir cualquier pregunta que se sienta incómoda al responder.

6. ¿CUÁLES SON MIS BENEFICIOS POR PARTICIPAR EN ESTE ESTUDIO?

Usted no puede beneficiarse directamente de esta investigación; sin embargo, esperamos que su participación en el estudio pueda tener beneficios de ayuda para otros. Además, su
voz en este proceso es necesario para explorar cómo podemos desarrollar mejores recursos e intervenciones para las mujeres expuestas a la violencia de la pareja.

7. ¿CUÁLES SON MIS RIESGOS AL PARTICIPAR EN ESTE ESTUDIO?

Los participantes serán informados de su derecho a detener la entrevista en cualquier momento que sientan que no pueden continuar. Aunque este estudio tiene riesgos mínimos, el aspecto emocional de hablar sobre sus experiencias de violencia de pareja íntima puede molestar a los participantes. Es por esta razón que la información sobre los recursos de salud mental y números de emergencia se dará a todos los participantes en la primera entrevista. Además, usted recibirá asistencia inmediata si es necesario.

8. ¿CÓMO SE PROTEGE MI INFORMACIÓN PERSONAL?

Para proteger la confidencialidad de su información en los registros del estudio, se utilizarán los siguientes procedimientos:

Las transcripciones no contendrán ninguna información de identificación personal. En su lugar, se utilizará un código para identificar los datos de la entrevista. Su nombre solo aparecerá en el consentimiento informado, que se mantendrá en un archivo cerrado, separado de los datos de la entrevista en la oficina cerrada del investigador. Las transcripciones y las grabaciones de audio serán etiquetadas con un código y también se mantendrán en un archivo cerrado en la oficina del investigador, pero separadas de los formularios de consentimiento. Se utilizará un seudónimo para referirse a usted durante la entrevista para garantizar la confidencialidad. Una clave maestra que vincula su nombre y un código de estudio se mantendrá en un archivo seguro y separado. La clave maestra y las cintas de audio serán destruidas 3 años después del cierre de la investigación. Los códigos de los participantes se utilizarán en todos los datos electrónicos, este no contiene información identificable. Cualquier computadora que aloje tales archivos tendrá protección por contraseña para impedir el acceso de usuarios no autorizados y sólo tendrá acceso el investigador. BOX, que es una unidad protegida, se utilizará para almacenar todos los datos electrónicos. El archivo BOX estará accesible sólo al investigador y al asesor. Al final de este estudio, los investigadores pueden
publicar sus hallazgos. La información se presentará en formato de resumen y no se identificará en ninguna publicación o presentación.

9. ¿RECIBIRÉ UN PAGO PARA PARTICIPAR EN EL ESTUDIO?
Al final de cada entrevista, el participante recibirá un estipendio monetario de $10 dólares para cubrir los costos de transportación, para un total de $20 dólares por las 2 entrevistas. Si el participante termina prematuramente la participación, recibirá $10 para cubrir los costos de transportación. Si las mujeres terminan prematuramente la primera entrevista, no puede ser incluida en el estudio, o ser entrevistada por segunda vez.

10. ¿QUÉ SUCEDE SI TENGO PREGUNTAS?
Tómese el tiempo que quiera antes de tomar una decisión. Estaremos encantados de responder cualquier pregunta que tenga sobre este estudio. Si tiene más preguntas sobre este proyecto o si tiene un problema relacionado con la investigación, puede ponerse en contacto con las investigadoras:

Lourdes Irene
*Teléfono:* (787) 925-4999  
*Correo electrónico:* lirene@nursing.umass.edu o lourdes.irene@upr.edu

Karen Kalmakis
*Teléfono:* 1-413-577-4763  
*Correo electrónico:* kalmakis@nursing.umass.edu

Si tiene alguna pregunta sobre sus derechos como sujeto de investigación, puede comunicarse con la oficina de protección de la investigación humana (HRPO por sus siglas en inglés) de la Universidad de Massachusetts Amherst al (413) 545-3428 o humansubjects@ora.umass.edu.

11. ¿PUEDO DEJAR EL ESTUDIO?
Su participación es voluntaria, y usted no tiene que estar en este estudio si no lo desea. Si usted está de acuerdo en participar en el estudio, pero más tarde cambia de opinión, puede dejarlo en cualquier momento. No hay sanciones o consecuencias de ningún tipo si decide que no quiere participar.
Usted puede cancelar esta autorización en cualquier momento enviando una notificación por escrito a las investigadoras en la siguiente dirección:

**Lourdes Irene**

Universidad de Puerto Rico  
Recinto de Ciencias Médicas  
Escuela de Enfermería  
PO Box 365067  
San Juan, Puerto Rico 00936  
o por correo electrónico a lirene@nursing.umass.edu or lourdes.irene@upr.edu

**Karen Kalmakis**  
Universidad de Massachusetts  
School of Nursing  
Skinner Hall 222  
651 North Pleasant Street  
Amherst, MA 01003-9277  
o por correo electrónico a kalmakis@nursing.umass.edu

**12 ¿QUÉ PASA SI ME LESIONO?**

La Universidad de Massachusetts no tiene un programa para compensar a los sujetos por lesiones o complicaciones relacionadas con la investigación de sujetos humanos, pero el personal del estudio le ayudará a obtener tratamiento.

**13. DECLARACIÓN DE CONSENTIMIENTO VOLUNTARIO**

Al firmar este formulario estoy de acuerdo en entrar voluntariamente en este estudio. He tenido oportunidad de leer este formulario de consentimiento, y me fue explicado en el lenguaje que utilizo y entiendo. He tenido la oportunidad de hacer preguntas y haber recibido respuestas satisfactorias. Entiendo que me puedo retirar del estudio en cualquier momento. Una copia de este formulario firmado de consentimiento me será entregada.

_______ Estoy de acuerdo en que segmentos de las grabaciones de mi participación en esta investigación pueden ser utilizados para presentaciones de conferencias, así como para la educación y capacitación de futuros investigadores / practicantes.
______Estoy de acuerdo en archivar mis grabaciones para futuras investigaciones en el campo de la Violencia de Pareja Intima.

______No estoy de acuerdo en permitir que segmentos de grabaciones de mi participación en esta investigación se utilicen para presentaciones de conferencias o para fines de educación y capacitación.

______Acepto la grabación de audio

______ No estoy de acuerdo con la grabación de audio

Firma del Participante  Nombre en letra de molde  Fecha

La firma en el siguiente espacio indica que el participante ha leído y en mi conocimiento, entiende la información contenida en este documento y se le ha entregado una copia.

Firma de la Persona que obtiene el consentimiento  Nombre en letra de molde  Fecha

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APPENDIX C

DEMOGRAPHIC INSTRUMENT

University of Massachusetts Amherst

School of Nursing

Instructions: Of the following question, please select the best category that applies to you. You do not need to provide your name. If you need help, ask the investigator for assistant.

All information will be kept confidential.

1. What is your age: _______

2. What is the age of partner? ________

3. What is marital status (circle one):
   a. Single
   b. Married
   c. Living with partner
   d. Separated
   e. Divorced
   f. Widowed
   g. Other (please describe): ____________________________

4. What is your highest educational level (circle one)?
   a. Less than High School Diploma
   b. High School Diploma
   c. Associate degree
   d. Bachelor’s Degree
   e. Post-graduate work or advanced degree

5. Do you have a job (circle one)?
   No
   Yes
   a. If yes, how many hours on average do you work in one week? _________
   b. If yes, describe your job:
      __________________________________________
      __________________________________________
      __________________________________________
6. How appropriate was your income to cover your daily expenses in the relationship with your partner (circle one):
   a. Enough
   b. Just suitable
   c. Totally inappropriate

7. Do you own your home (circle one)?
   Yes
   No

8. Do you have children (circle one)?
   Yes
   No
   How many: ________________

9. Do you have a medical plan (circle one)?
   Yes
   No

10. You have a health condition? (Circle all the apply)
    a. Hypertension
    b. Diabetes
    c. Asthma
    d. High cholesterol
    e. Cancer
    f. Thyroid
    g. Other:
        __________________________________________________________

11. Do you take any medicine? If yes, please list the name(s) of the medication(s) you are taking (circle one).
    Yes
    No
    Medications:
    __________________________________________________________
In-depth Interview Guideline

Aim: The aims of this study are: to explore the experiences of IPV in a sample of Puerto Rican women over 60 years of age and to consider the effects of IPV on women's health.

Date: ___________________________                   Time: ________________________

Person interviewing: _______________________   Place: ________________________

My name is Lourdes Irene, doctoral student from PhD program in the University of Massachusetts in Amherst. Thank you for agreeing to talk with me and participate in this study. I realize that this subject of the study may be sensitive to some, therefore, please do not hesitate to let me know if at any time you want to take a break or withdrawal from the interview.

Well, we're about to start the interview. As I explained above, it will be recorded because I want to keep all my attention in the conversation that we will have. I would like to know, before starting to record, if you prefer to be called by another name other than yours. This way you will be sure that the information you provide will not be associated with you, but with the name that you choose. What name would you like to use during recording? ____________ (pseudonym). All right, I'll call you that way.

We'll start the interview by talking about:

- Childhood
- Experience of abuse
- Experience of abuse revealed to others or to health professionals (nurses, doctors, among others)
**First interview**

*Experiences to IPV*

1. Tell me about your childhood.

Example Probes:

   a. Tell me about your childhood.
   b. Tell me about your relationship with your family.
   c. Who lived in your home (parents, siblings, others).
   d. As was the relationship between his parents.
   e. Tell me about how your family related to the community, church, and others.
   f. In your childhood or adolescence did you witness an act of intimate partner violence in the community, school, work or other settings? Tell me more about when, how, who and where it happened. Did this situation affect you at that time? How did you react to?

Now let's talk about your experience with the intimate partner violence

2. Tell me about your experience of IPV

Example Probes:

   a. When it was the first time she experienced intimate partner violence.
   b. Tell me how you reacted that first time
   c. Tell me about your experience with intimate partner violence.
   d. What were some of the things he said or did?
   e. Tell me how you felt.
   f. How did that person treat you?
   g. Do you feel comfortable sharing more about this with me?
   h. How long did the relationship last?
   i. How long has it been since this?
   j. Tell me about the worst moment; tell me about the last time
   k. Tell me how this experience has affected your life.

We will continue to talk about your personal beliefs and intimate partner violence experience

3. Tell me about how this experience has affected your life and your beliefs.

Example Probes:

   a. Tell me your opinion of how you see the raising of woman in Puerto Rico.
   b. How do you think this rearing of women influences a relationship of partner violence?
c. If you were not Puerto Rican, do you think it would be the same or different? Tell me if not being Puerto Rican can influence differently.
d. Can you tell me if your religious beliefs influenced your experiences of abuse?

We will continue to talk about your abuse experience and your state of health.

4. Do you believe that this experience has affected your health, if so how?

Example Probes:

a. I want you to think about your abuse experience and tell me if I somehow affect you physically. What happened?
b. Tell me about your emotional health.
c. Can you tell me if your experience of abuse caused you any illness?
d. What type of help do you looked for when you were experiencing violence with your partner?
e. Tell me about the reason that led you to seek help.
f. How was the care received?
g. Tell me about the treatment of health care providers toward you
h. Tell me if the care offered was what you expected.

We will now talk about sharing your experience with others.

5. Have you disclosed the abuse to another person?

Example Probes:

a. Who was that person?
b. What made trust that person?
c. How much did that person help you?

We will now talk about sharing your experience with health provider.

6. Have you talked about the abuse with your health provider (nurse, doctors, among others)?

Example Probes:

a. Who was the health care provider?
b. Tell me about what the health care provider told you
c. How did you feel about your abuse experience with that provider?
d. What made you trust that health care provider?
e. How did the provider help you?
Second interview

Thanks again for your participation in this study.

Now I'm going to read what I transcribed from your interview to validate the findings by comparing the results with your lived experience.

After reading and validating the findings, I will ask you some questions to reflect on the meaning of your experience.

Reflection on meaning

1. Can you share with me how you became the woman you are after living through this experience?

2. Tell me something you think we should know about the experience of abuse in the lives of older Puerto Rican Women.

3. Reflecting on the recent natural disaster in Puerto Rico, in what way have these affected your personal experience of intimate partner violence.

Is there anything else you would like to add?

Thank you for agreeing to participate in this research.

Prepared by Lourdes Irene/ 2017
Instrucciones: De las siguientes preguntas, seleccione la categoría que mejor le aplique a usted. No es necesario que proporcione su nombre. Si necesita ayuda, pida al investigador que le ayude.

Toda la información se mantendrá confidencial.

1. ¿Cuál es su edad?: _________

2. ¿Cuál es la edad de su pareja? _________

3. ¿Cuál es su estado civil? (circule uno):
   a. Soltera
   b. Casada
   c. Vive con su pareja
   d. Separada
   e. Divorciada
   f. Viuda
   g. Otro (por favor, describa): ____________________________

4. ¿Cuál es su nivel educativo más alto (circule uno)?
   a. Menos que el diploma de escuela secundaria
   b. Diploma de escuela secundaria
   c. Grado asociado
   d. Bachillerato
   e. Posgrado o título avanzado

5. ¿Usted trabaja (circule uno)?
   Si
   No
   a. En caso de contestar si, ¿cuántas horas de promedio trabaja en una semana? __________
   b. Si contestó que sí, describa su trabajo: _____________________________________________
6. Cuán apropiado fue su ingreso para cubrir sus gastos diarios en la relación con su pareja (circule uno):
   
a. Suficiente  
b. Adecuado  
c. Totalmente inapropiado

7. ¿Es dueño de su casa (circule uno)?
   
   Si
   No

8. ¿Tiene hijos (circule uno)?
   
   Si
   No
   
   Cuántos: ________________

9. ¿Tiene un plan médico (circule uno)?
   
   Si
   No

10. ¿Tiene alguna condición de salud? (Circule todas las que usted tenga)
   
a. Hipertensión
b. Diabetes
c. Asma
d. Colesterol alto
e. Cáncer
f. Tiroides
g. Otros:

11. ¿Toma algún medicamento (circule uno)? En caso de contestar que sí, indique el nombre de los medicamentos que está tomando.
   
   Si
   No
   
   Medicamentos:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Universidad de Massachusetts Amherst

Escuela de Enfermería

Guía de entrevista a profundidad

Objetivo: Los objetivos de este estudio son: explorar las experiencias de IPV en una muestra de mujeres puertorriqueñas mayores de 60 años y considerar los efectos del IPV sobre la salud de las mujeres.

Fecha: ___________________________                  Hora: ________________________
Persona entrevistada: _______________________   Lugar: _______________________

Mi nombre es Lourdes Irene, estudiante del programa de doctorado en la Universidad de Massachusetts en Amherst. Gracias por aceptar conversar conmigo y participar en este estudio. Me doy cuenta de que el tema del estudio puede ser sensible a algunos, por lo tanto, no dude en avisarme, si en cualquier momento desea tomar un descanso o terminar la entrevista.

Bueno, estamos a punto de comenzar la entrevista. Como he explicado anteriormente, la entrevista será grabada, porque quiero mantener toda mi atención en la conversación que tendremos. Me gustaría saber, antes de comenzar a grabar, si usted prefiere ser llamado por otro nombre que no sea el suyo. De esta manera estará segura de que la información que proporciona no estará asociada a usted, sino con el nombre que elija. ¿Qué nombre desea utilizar durante la grabación? _____________ (seudónimo). Muy bien, le llamaré de esa manera.

Comenzaremos la entrevista hablando de:

- Infancia
- Experiencia de abuso
- Experiencia de abuso revelado a otros profesionales de la salud (enfermeras, médicos, entre otros)
Primera entrevista

Experiencia de IPV

1. Cuénteme sobre su infancia.

Ejemplo de preguntas para explorar el tema:

a. Cuénteme sobre su niñez.
b. Hábleme sobre cómo era la relación de usted con su familia.
c. Quienes vivían en su hogar (padres, hermanos, otros).
d. Como era la relación entre sus padres.
e. Hábleme sobre como su familia se relacionaba con la comunidad, iglesia y otros.
f. ¿En su infancia o adolescencia fue testigo de un acto de violencia de pareja en la comunidad, en la escuela, en el trabajo u otros lugares? Cuénteme más sobre cuándo, cómo, quién y dónde sucedió. ¿Le afectó esta situación en ese momento? ¿Cómo reaccionó?

Ahora hablemos de su experiencia con la violencia de la pareja

2. Hábleme sobre su experiencia de IPV.

Ejemplo de preguntas para explorar el tema:

a. Cuando fue la primera vez que experimentó violencia de pareja íntima.
b. Dígame cómo reaccionó esa primera vez.
c. Hábleme sobre su experiencia con la violencia de pareja íntima.
d. ¿Cuáles fueron algunas de las cosas que dijo o hizo?
e. Hábleme de cómo se sentía.
f. ¿Cómo te trató esa persona?
g. ¿Te sientes cómodo compartiendo más sobre esto conmigo?
h. ¿Cuánto duró la relación?
i. ¿Cuánto tiempo ha pasado desde esto?
j. Háblame del peor momento; Cuéntame de la última vez
k. Dime cómo esta experiencia ha afectado tu vida.

Continuaremos hablando de sus creencias personales y experiencias de violencia de pareja

3. Háblame de cómo esta experiencia ha afectado tu vida y tus creencias.

Ejemplo de preguntas para explorar el tema:

a. Dígame su opinión de cómo ve la crianza de una mujer en Puerto Rico.
b. ¿Cómo crees que esta crianza de mujeres influye en una relación de violencia de pareja?

c. Si usted no fuera puertorriqueña, ¿crees que sería igual o diferente? Dime si no ser puertorriqueña puede influir de manera diferente.

d. ¿Puede decirme si sus creencias religiosas influenciaron sus experiencias de abuso?

Continuaremos hablando sobre su experiencia de abuso y su estado de salud

4. ¿Cree usted que esta experiencia ha afectado su salud, si es así cómo?

Ejemplo de preguntas para explorar el tema:

   a. Quiero que piense en su experiencia de abuso y me diga si de alguna manera le afectó físicamente. ¿Qué le ocurrió?
   b. Háblame de su salud emocional.
   c. ¿Puede decirme si su experiencia de abuso le causó alguna enfermedad?
   d. ¿Qué tipo de ayuda buscó cuando experimentó violencia con su pareja?
   e. Háblame de la razón que la llevó a buscar ayuda.
   f. ¿Cómo fue el cuidado recibido?
   g. Cuénteme sobre el trato de los proveedores de atención médica hacia usted.
   h. Dígame si el cuidado ofrecido fue lo que esperaba.

Ahora hablaremos sobre el compartir la información de su experiencia con otros.

5. Ha revelado el abuso a otra persona

Ejemplo de preguntas para explorar el tema:

   a. ¿Quién era esa persona?
   b. ¿Qué le hizo confiar en esa persona?
   c. ¿Cómo le ayudó esa persona?

Ahora hablaremos sobre compartir la información de su experiencia con el proveedor de servicios de salud

6. Ha hablado sobre el abuso con su proveedor de salud (enfermera, médicos, entre otros).

Ejemplo de preguntas para explorar el tema:

   a. ¿Quién fue el proveedor de atención médica?
   b. Háblame de lo que le dijo.
   c. ¿Cómo te sentiste con ese proveedor?
   d. ¿Qué le hizo confiar en ese proveedor de atención médica?
   e. ¿Cómo le ayudó el proveedor?
**Segunda entrevista**

Gracias de nuevo por su participación en este estudio.

Ahora voy a leer lo que transcribí de su entrevista para validar los hallazgos comparando los resultados con su experiencia vivida.

Después de leer y validar los resultados, le haré algunas preguntas para reflexionar sobre el significado de su experiencia.

**Reflexión sobre el significado**

1. ¿Puede compartir conmigo cómo se convirtió en la mujer que es ahora, después de vivir esta experiencia?

2. Dígame algo que usted piensa que debemos saber sobre la experiencia de abuso en las vidas de mujeres puertorriqueñas mayores.

3. Reflexionando sobre el reciente desastre natural en Puerto Rico, de qué manera esto ha afectado su experiencia personal de violencia en la pareja.

¿Hay algo más que le gustaría agregar?

Gracias por aceptar participar en esta investigación.

Preparado por Lourdes Irene/ 2017
## APPENDIX D

### DEMOGRAPHIC DATA AND HEALTH DATA

Table 3: Demographic data and health data

<table>
<thead>
<tr>
<th>Age</th>
<th>Age of partner</th>
<th>Marital status</th>
<th>Educational level</th>
<th>Job</th>
<th>Income</th>
<th>Home</th>
<th>Children</th>
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<tr>
<td>Morena</td>
<td>62 years</td>
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<td>Morena</td>
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<td></td>
<td></td>
<td>Separated</td>
<td>High School Diploma</td>
<td>No</td>
<td>Just suitable</td>
<td>No</td>
<td>1 (one of the first partner)</td>
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<table>
<thead>
<tr>
<th>Carmen</th>
<th>66 years</th>
<th>Carmen</th>
<th>Carmen</th>
<th>Carmen</th>
<th>Carmen</th>
<th>Carmen</th>
<th>Carmen</th>
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<tbody>
<tr>
<td></td>
<td>67 years</td>
<td>Divorced</td>
<td>Bachelor’s Degree in computer</td>
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<td>Totally inappropriate</td>
<td>Yes</td>
<td>2 (two of the first partner)</td>
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<table>
<thead>
<tr>
<th>Violeta</th>
<th>73 years</th>
<th>Violeta</th>
<th>Violeta</th>
<th>Violeta</th>
<th>Violeta</th>
<th>Violeta</th>
<th>Violeta</th>
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<tbody>
<tr>
<td></td>
<td>70 years</td>
<td>Divorced</td>
<td>High School Diploma</td>
<td>No</td>
<td>Totally inappropriate</td>
<td>Yes</td>
<td>Three from first partner</td>
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<table>
<thead>
<tr>
<th>Lucy</th>
<th>66 years</th>
<th>Lucy</th>
<th>Lucy</th>
<th>Lucy</th>
<th>Lucy</th>
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<tbody>
<tr>
<td></td>
<td>85 years</td>
<td>Married</td>
<td>High School Diploma</td>
<td>No</td>
<td>Enough with his money</td>
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<tr>
<th>Glory</th>
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<tr>
<td></td>
<td>88 years</td>
<td>Married</td>
<td>Seventh grade</td>
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<tr>
<th>Debona</th>
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<tr>
<td></td>
<td>75 years</td>
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<td>High School Diploma</td>
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### Health data

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<td>Yes</td>
<td>bladder-urinary problems polyps in colonoscopy hysterectomy detached retina glaucoma osteoporosis rheumatoid arthritis major depression nerves nerves bipolarity</td>
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<tr>
<td><strong>Carmen</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>high cholesterol hyperthyroidism anxiety arthritis</td>
<td></td>
</tr>
<tr>
<td><strong>Violeta</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>high cholesterol hyperthyroidism breast cancer, mastectomy thyroid glaucoma</td>
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<tr>
<td><strong>Lucy</strong></td>
<td></td>
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<tr>
<td>Yes</td>
<td>Hypertension Diabetes Anxiety</td>
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<tr>
<td><strong>Glory</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>high cholesterol thyroid Parkinson Depression Sleep problems</td>
<td></td>
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<tr>
<td><strong>Debora</strong></td>
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<td></td>
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<tr>
<td>Yes</td>
<td>Hypertension - after the event vertebral column (discs) bladder cancer</td>
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<tr>
<td></td>
<td>Synthroid Lovastatin Losartan Eye drops</td>
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<tr>
<td></td>
<td>Levothyroxine Zoloft</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Synthroid Lovastatin Losartan Eye drops</td>
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</tr>
<tr>
<td></td>
<td>Lisinopril Metformin Zoloft Clonazepam</td>
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<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clonazepam- stopped using this medication</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX E
MENTAL HEALTH RESOURCES

Dra. María del C. Declet Braña
Clinical Psychologist Lic. 307
Condominio Olimpo Plaza
1002 Ave. Muñoz Rivera, Suite 205
San Juan, PR 00927
787-763-0064
mcdeclet@gmail.com

CERTIFICATION

June 2, 2017

Prof. Lourdes Irene López
Assistant Professor

The title of my dissertation research is: Older Women’s Experiences of Intimate Partner Violence: A Phenomenological Study

Crisis intervention services will be used if necessary during the course of the interview with the participants. This interviews are part of my doctoral dissertation to complete a PhD with the University of Massachusetts, Amherst.

Counseling services

During the course of the field work of the thesis of Lourdes Irene Lopez in which two depth interviews they will be conducted with women aged survivors of intimate partner violence, may arise by crisis events evoked flash back. I certify that if a person is disorganized emotionally will be available to provide crisis intervention first order.

Maria del C. Declet Braña PhD
Lic. 307
Thank you for your participation in our study! Your participation is greatly appreciated.

Purpose of the Study:
We previously informed you that the purpose of the study was to explore and describe the experiences and perceptions related to the phenomenon of intimate partner violence among Puerto Rican women over age 60.

We realize that some of the questions asked may have provoked strong emotional reactions. As researchers, we do not provide mental health services and we will not be following up with you after the study. However, we want to provide every participant in this study with a comprehensive and accurate list of clinical resources that are available, should you decide you need assistance at any time. Please see information pertaining to local resources at the end of this form.

Confidentiality:
You may decide that you do not want your data used in this research. If you would like your data removed from the study and permanently deleted please sending a written notice to the investigator at the following address:

Lourdes Irene
University of Puerto Rico
Medical Sciences Campus
School of Nursing
PO Box 365067
San Juan, Puerto Rico 00936

or by email at lirene@nursing.umass.edu or lourdes.irene@upr.edu

Whether you agree or do not agree to have your data used for this study, you may keep the $20 dollars for your participation
Final Report:

If you would like to receive a copy of the final report of this study (or a summary of the findings) when it is completed, please feel free to contact at the following address:

**Lourdes Irene**

**University of Puerto Rico**

**Medical Sciences Campus**

**School of Nursing**

**PO Box 365067**

**San Juan, Puerto Rico 00936**

or by email at l Irene@nursing.umass.edu or lourdes.irene@upr.edu

Useful Contact Information:

If you have any questions or concerns regarding this study, its purpose or procedures, or if you have a research-related problem, please feel free to contact the researcher, Lourdes Irene at (787) 925-4999 or by email at lirene@nursing.umass.edu or lourdes.irene@upr.edu

If you have any questions concerning your rights as a research subject, you may contact the University of Massachusetts Amherst Human Research Protection Office (HRPO) at (413) 545-3428 or humansubjects@ora.umass.edu.

If you feel upset after having completed the study or find that some questions or aspects of the study triggered distress, talking with a qualified clinician may help. If you feel you would like assistance please contact Dr. Maria del C. Declet Braña, Clinical Psychologist at (787) 763-0064. Or you can contact the following resources:
Directory of referrals resources for mental health services

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<th>Líneas telefónicas- Phone numbers</th>
</tr>
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<td><strong>Emergencias</strong></td>
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<tr>
<td>911</td>
<td>Línea de PAS de ASSMCA 1-800-981-0023/ 787-763-7575</td>
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<tr>
<td></td>
<td>Línea de crisis de suicidio nacional 1-800-784-2432</td>
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<td>Línea nacional de vida 1-800-273-8255/1-888-628-9454</td>
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<tr>
<td></td>
<td>Víctimas de violencia doméstica 787-724-1596</td>
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<td></td>
<td>Procuraduría de las mujeres 787-721-7676</td>
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<tr>
<td></td>
<td>Hospital Panamericano 1-800-981-1218</td>
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<td></td>
<td>Instituto Psicoterapéutico de Puerto Rico 1-800-284-9515/787-753-9515</td>
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<td>APS HealthCare 1-800-503-7929</td>
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<td>Centro de ayuda a víctimas de violación 1-800-981-5721/787-765-2285</td>
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<td>Oficina del procurador de las personas de edad avanzada 787-721-6121</td>
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<td>Hospital de Psiquiatría- Dr. Ramón Fernández Marina 787-766-4646</td>
</tr>
<tr>
<td></td>
<td>Hospital San Juan Capestrano 1-888-967-4357</td>
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**Further Reading(s):**

If you would like to learn more about *intimate partner violence* please see the following references:


***Please keep a copy of this form for your future reference. Once again, thank you for your participation in this study!***
¡Gracias por su participación en nuestro estudio! Tu participación es apreciada.

Propósito del estudio:
Anteriormente le informamos que el propósito del estudio era explorar y describir las experiencias y percepciones relacionadas con el fenómeno de la violencia de pareja en mujeres puertorriqueñas mayores de 60 años.
Algunas de las preguntas formuladas pueden provocar fuertes reacciones emocionales.
Como investigadores, no proporcionamos servicios de salud mental y no seguiremos con usted después del estudio. Sin embargo, queremos proporcionar a cada participante en este estudio una lista completa y precisa de los recursos clínicos disponibles, en caso de que decida que necesita asistencia en cualquier momento. Consulte la información relacionada a los recursos locales al final de este formulario.

Confidencialidad:
Puede decidir que no desea que sus datos se utilicen en esta investigación. Si desea que sus datos sean eliminados del estudio y eliminados permanentemente, envíe un aviso por escrito al investigador a la siguiente dirección:

Lourdes Irene

Universidad de Puerto Rico
Reciento de Ciencias Médicas
Escuela de Enfermería
PO Box 365067
San Juan, Puerto Rico 00936

o por correo electrónico irene@nursing.umass.edu o lourdes.irene@upr.edu

Si usted está de acuerdo o no está de acuerdo en que sus datos sean utilizados para este estudio, usted seguirá recibiendo $ 20 dólares por su participación.
Reporte Final:
Si desea recibir una copia del informe final de este estudio (o un resumen de los hallazgos) cuando se haya completado, puede ponerse en contacto con la siguiente dirección:

Lourdes Irene
Universidad de Puerto Rico
Reciento de Ciencias Médicas
Escuela de Enfermería
PO Box 365067
San Juan, Puerto Rico 00936
o por correo electrónico lirene@nursing.umass.edu o lourdes.irene@upr.edu

Información de contacto útil:
Si tiene alguna pregunta o inquietud con respecto a este estudio, su propósito o procedimientos, o si tiene un problema relacionado con la investigación, no dude en comunicarse con el investigador, Lourdes Irene (787) 925-4999 o por correo electrónico lirene@nursing.umass.edu o lourdes.irene@upr.edu

Si tiene preguntas sobre sus derechos como sujeto de investigación, puede comunicarse con la Oficina de Protección de la Investigación Humana de la Universidad de Massachusetts, Amherst (HRPO) al (413) 545-3428 o humansubjects@ora.umass.edu.

Si usted se siente molesto después de haber completado el estudio o ha encontrado que algunas preguntas o aspectos del estudio desencadenaron angustia, hablar con un clínico calificado puede ayudarle. Si usted entiende que le gustaría recibir asistencia por favor comuníquese con la Dra. María del C. Declet Braña, Psicóloga Clínica al (787) 763-0064. O puede ponerse en contacto con los siguientes recursos:
Directorio de recursos de referencias para servicios de salud mental

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<th>Líneas telefónicas- Phone numbers</th>
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<td>1-800-273-8255/1-888-</td>
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<tr>
<td>Hospital de Psiquiatría- Dr. Ramón Fernández Marina</td>
<td>787-766-4646</td>
</tr>
<tr>
<td>Hospital San Juan Capestrano</td>
<td>1-888-967-4357</td>
</tr>
</tbody>
</table>

**Lectura (s) adicional (es):**
Si desea obtener más información sobre la violencia de pareja, consulte las siguientes referencias:
https://www.cdc.gov/violenceprevention/intimatepartnerviolence/
https://www.nij.gov/topics/crime/intimate-partner-violence/Pages/welcome.aspx

*** Guarde por favor una copia de este formulario para su referencia futura. Una vez más, gracias por su participación en este estudio ***
APPENDIX G

CRISIS PLAN

English version

This plan has been designed with the purpose of reducing the effects that could produce an emotional crisis in the event that any participant refers to an emotional problem or presents any of the following symptoms: crying, fear, irritability, tremors, despair, or any other Manifestation of emotional crisis during the deep interview. In case this happens, the following steps will be followed:

1. The researcher will stop the interview process and remain with the participant at all times in the office in which the deep interview is being developed. The office meets the minimum requirements of confidentiality, privacy and security. The researcher will maintain a calm attitude, of empathy and respect. Besides, will let the participant know his intention to help. Will be use the technique of silence to give the participant time to calm down and organize his thoughts, he will also communicate that if he wishes to speak he can do it. The researcher will actively listen without judgment and with empathy.

2. The researcher will be contact the clinical psychologist Dr. María Declet by telephone to intervene with the participant by telephone. This intervention will be carried out in the office described above and in the presence of the researcher.

3. The Clinical Psychologist María Declet, will offer the first psychological help and stabilize the person by telephone. The psychologist will do the following:
   a. Will be explain the purpose of the intervention.
b. It will ask open and closed questions to estimate the situation of the participant and the level of risk.

c. The clinical psychologist will establish an aid plan and establish an agreement with the participant. She will explain to the participant what the support plan will consist of.

d. The psychologist will request information from a mental health service provider (psychologist, psychiatrist) in case the participant has previously received these services.

e. The clinical psychologist will also ask the participant for information from a close relative or other available support resource (friend, neighbor, pastor, priest, etc.).

4. The researcher will call the next of kin or the support resource that the participant identifies. This it is must go to the office and receive precise instructions so that the participant can receive the necessary services.

5. The researcher will coordinate the evaluation and the psychological or psychiatric services recommended by the psychologist. In case the participant has a provider of psychological or psychiatric services, the researcher will contact that professional to attend the participant immediately. In the event that this professional is not available, the assistance will be channeled through the ASSMCA PAS Line 1-800-981-0023.

6. The researcher will explain to both the participant and the family member the importance of receiving help on the same day.
Plan de crisis emocional

Spanish version

Este plan ha sido diseñado con el propósito de reducir los efectos que pudiera producir una crisis emocional en el caso de que algún participante refiera algún problema emocional o presente alguno de los siguientes síntomas: llanto, miedo, irritabilidad, temblores, desesperación, o cualquier otra manifestación de crisis emocional durante la entrevista profunda. En caso de que esto ocurra se seguirán los siguientes pasos:

1. La investigadora detendrá el proceso de entrevista y permanecerá junto al participante en todo momento en la oficina en la cual se está desarrollando la entrevista profunda. La oficina cumple con los requisitos mínimos de confidencialidad, privacidad y seguridad. La investigadora mantendrá una actitud calmada, de empatía y de respeto. Le hará saber al participante su intención de ayudarle. Utilizará la técnica del silencio para darle tiempo al participante de calmarse y organizar sus pensamientos, también le comunicará que si desea hablar lo puede hacer. La investigadora escuchará activamente sin juzgar y con empatía.

2. La investigadora contactará telefónicamente a la Psicóloga clínica María Declet para que intervenga con el participante por vía telefónica. Esta intervención se realizará en la oficina descrita anteriormente y en presencia de la investigadora. En ningún momento se dejará a la participante sola, ni antes, durante o después de hablar con la psicóloga.

3. La Psicóloga clínica María Declet, ofrecerá los primeros auxilios psicológicos y estabilizará a la persona por teléfono. La psicóloga realizará lo siguiente:
   a. Se identificará y explicará al participante el propósito de su intervención.
b. Realizará preguntas abiertas y cerradas para estimar la situación del participante y el nivel de riesgo.

c. La psicóloga clínica establecerá un plan de ayuda y establecerá un acuerdo con el participante. Le explicará al participante en qué consistirá el plan de ayuda.

d. La psicóloga solicitará información de un proveedor de servicios de salud mental (psicólogo, psiquiatra) en caso de que el participante haya recibido estos servicios previamente.

e. La psicóloga clínica también le solicitará al participante información de algún familiar cercano u otro recurso de apoyo disponible (amigo, vecino, pastor, sacerdote, etc.).

4. La investigadora llamará al familiar cercano o el recurso de apoyo que el participante identifique. El mismo deberá acudir a la oficina y recibirá instrucciones precisas para que el participante reciba los servicios necesarios.

5. La investigadora coordinará la evaluación y los servicios psicológicos o psiquiátricos recomendados por la psicóloga. En caso de que el participante cuente con un proveedor de servicios psicológicos o psiquiátricos, la investigadora contactará a ese profesional para que atienda al participante de inmediato. En caso de que este profesional no esté disponible se canalizará la ayuda a través de la Línea PAS de ASSMCA 1-800-981-0023.

6. La investigadora explicará tanto al participante como al familiar, la importancia de recibir la ayuda ese mismo día.
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